Petition

81-1791

Supreme Court, U.S.
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No. .....

In the

Supreme Court of the United States

OCTOBER TERM, 1981

GROUP LIFE AND HEALTH INSURANCE COMPANY,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT, UNIT A

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QUESTIONS PRESENTED

I.

Whether the Court of Appeals erred in holding that:

> the $750/$1,000 reserve factor used by Petitioner's actuary in establishing the reserve for its 23 disabled insureds for the year 1967 did not qualify as a life reserve under Section 801(b), Internal Revenue Code, as amounts "which are computed or estimated on the basis of recognized mortality or morbidity tables", and, therefore, Petitioner was not taxable as a life insurance company.

II.

Whether the Court of Appeals erred in holding that:

> the oral demands for additional deductions supported by written documents submitted by Petitioner to a Revenue Agent, and in fact allowed by a Revenue Agent and the Commissioner, were not informal claims for refund within the meaning of Section 6511, Internal Revenue Code, for the year 1967.

LIST OF ALL PARTIES

The parties to this case are as appear in the Caption. However, the first issue in this case is raised in at least three pending cases not yet decided and has industry-wide significance[1]. Petitioner is a wholly owned subsidiary of Group Hospital Services, Inc. and is affiliated with Group Medical & Surgical Services, Inc. and both are Texas corporations.

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[1]Cases known pending are *Gulf Life Insurance Co. v. United States*, No. 75-793-CIV-J-S, (DC MD, Fla.), *John Hancock Mutual Life Insurance Co. v. United States*, No. 319-75, (Ct. Cl.) and *Travelers Insurance Co. v. United States*, No. 422-80T, (Ct. Cl.). Petitioner has been advised by counsel for numerous life insurance companies that the same issue involving millions of dollars is pending administratively on claims for refund awaiting the outcome of this case.

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UNITED STATES OF AMERICA,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT, UNIT A

Group Life and Health Insurance Company (hereinafter called Petitioner) petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit, Unit A, in this case.

OPINIONS BELOW

The decision of the District Court (App. A, *infra*)[2] is not officially reported. It is unofficially reported at 78-2 USTC

[2] "App." refers to the appendix to this petition. "R." references are to the record in the Court of Appeals.

9797 and 42 AFTR 2d 78-6282. The opinion of the Court of Appeals (App. C, *infra*) is reported in 48 AFTR 2d 81-6180, and 81-2 USTC 9773.

JURISDICTION

The judgment of the Court of Appeals was entered on November 12, 1981, (App. C, *infra*). By order dated November 20, 1981, the time period for filing the Petition for Rehearing was extended to December 26, 1981. Petition for Rehearing and Petition for Rehearing En Banc were filed on December 23, 1981, and were denied on January 6, 1982, (App. D, *infra*). The jurisdiction of this Court is invoked under 28 USCA, Section 1254(1).

STATUTES AND REGULATION INVOLVED

The relevant provisions of the Internal Revenue Code of 1954, as amended by the Life Insurance Company Income Tax Act of 1959, and Treasury Regulation, Sec. 301. 6402-2(b) are set forth below:

SEC. 801. DEFINITION OF LIFE INSURANCE COMPANY.

(a) *Life Insurance Company Defined.* — For purposes of this subtitle, the term "life insurance company" means an insurance company which is engaged in the business of issuing life insurance and annuity contracts (either separately or combined with health and accident insurance),

or noncancellable contracts of health and accident insurance, if —

(1) its insurance reserves (as defined in subsection (b)), plus

(2) unearned premiums and unpaid losses (whether or not ascertained), on noncancellable life, health, or accident policies not included in life insurance reserves,

comprise more than 50 percent of its total reserves (as defined in subsection (c)).

(b) *Life Insurance Reserves Defined.* —

(1) *In general.* — For purposes of this part, the term "life insurance reserves" means amounts —

(A) which are computed or estimated on the basis of recognized mortality or morbidity tables and assumed rates of interest, and

(B) which are set aside to mature or liquidate, either by payment or reinsurance, future unaccrued claims arising from life insurance, annuity, and noncancellable health and accident insurance contracts (including life insurance or annuity contracts combined with noncancellable health and accident insurance) involving, at the time with respect to which the reserve is computed, life, health, or accident contingencies.

(2) *Reserves must be required by law.* — Except —

(A) in the case of policies covering life, health, and accident insurance combined in one policy issued on the weekly premium payment plan, continuing for life and not subject to cancellation, and

(B) as provided in paragraph (3),

in addition to the requirements set forth in paragraph (1), life insurance reserves must be required by law.

SEC. 6511. LIMITATIONS ON CREDIT OR REFUND.

(a) *Period of Limitation on Filing Claim.* — Claim for credit or refund of an overpayment of any tax imposed by this title in respect of which tax the taxpayer is required to file a return shall be filed by the taxpayer within 3 years from the time the return was filed or 2 years from the time the tax was paid, whichever of such periods expires the later, or if no return was filed by the taxpayer, within 2 years from the time the tax was paid. Claim for credit or refund of an overpayment of any tax imposed by this title which is required to be paid by means of a stamp shall be filed by the taxpayer within 3 years from the time the tax was paid.

TREASURY REGULATION SEC. 301.6402-2(b)

(b) *Grounds set forth in claim.* (1) No refund or credit will be allowed after the expiration of the statutory period of limitation applicable to the filing of a claim therefor except upon one or more of the grounds set forth in a claim filed before the expiration of such period. The claim must set forth in detail each ground upon which a credit or refund is claimed and facts sufficient to apprise the Commissioner of the exact basis thereof. The statement of the grounds and facts must be verified by a written declaration that it is made under the penalties of perjury. A claim which does not comply with this paragraph will not be considered for any purpose as a claim for refund or credit.

STATEMENT

In this suit for the refund of Federal income taxes, the first issue is whether Petitioner is taxable as a life insurance company for 1967 under Section 801(a), Internal Revenue

Code[3], which requires that life insurance reserves be more than 50% of total reserves. Jurisdiction was vested in the District Court pursuant to 28 USCA Sec. 1346(a)(1). In the trial court it was undisputed that Petitioner needed only $59,020 (or $527 per thousand of insurance involved) of additional life reserves to meet the more than 50% life insurance company test of Section 801(a). Life reserves are defined in Section 801(b) to be amounts "which are computed or estimated on the basis of recognized mortality or morbidity tables and assumed rates of interest" and must be required by law.

Petitioner established at December 31, 1967, a reserve in the amount of $84,000 for disability-disabled lives for its group term life insurance policies. This reserve was computed by Petitioner's actuary at the rate of $750 per $1,000 ($750/$1,000) of life insurance coverage for which premiums were being waived due to total disability of the insured, which amount was based on a long-standing and widespread standard or estimate used in the industry. (III-R-76, IV-R-46-49) At year-end 1967 Petitioner had 23 insureds who were covered under group term life contracts having total life insurance coverage of $112,000 whose premiums were being waived due to total disability. (III-R-76, 106) Petitioner's group policy required a six-month period of disability before the waiver of premium benefit became applicable. Petitioner had no such disabled insureds at the end of 1966. Therefore, the period of disability for the 23 insureds was at least six months, but less than one year of duration, at the end of 1967. The Commissioner determined that the $84,000 reserve was not a life insurance reserve and that Petitioner was thus not a

[3]All section references are to the Internal Revenue Code of 1954, as amended by the Life Insurance Company Income Tax Act of 1959, unless otherwise identified.

life insurance company for tax purposes. In a suit for the refund of the taxes assessed, the district court held that the reserve was a life insurance reserve. On an appeal by the Government, the Fifth Circuit held that no part of the reserve was a life insurance reserve.

Insurance companies first began in 1938 to write *group* life policies with a waiver of premium benefit for the insured who became disabled. (See App. E-3) Consequently, there were no mortality or morbidity tables in existence for this type of benefit and group actuaries developed the practice of using an estimated reserve factor of $750/$1,000 of life coverage. (III-R-21) The American Society of Actuaries acting through its Committee on Group Mortality and Morbidity undertook a study in 1948 to determine the proper method of reserving for this risk where group life policies are involved. Reserving for this risk in *group* policies was considered to be different from reserving for individual policies since group life policies generally require no medical examination and include people of all ages, as well as high risk and low risk groups. (III-R-20) The Report of the Committee was the result of this study (attached as App. E and herein referred to as the 1949 Report). Except for the industry-wide estimate of $750/$1,000 and the 1949 Report there were no other recognized mortality or morbidity tables or standards in existence in 1967 to compute this reserve although a reserve was needed for this benefit.

The Committee's purpose was to develop actual statistical experience on the waiver of premium benefits, primarily to determine if the industry-wide estimate of using $750/$1,000 was reasonable. (III-R-21) The confirmation of the appropriate reserve was not only necessary for company reserve requirements, it also was necessary in determining the charge to be made against each group policy for calcu-

lating the "Experience Refund" to the group. In Section II, entitled "Disability Claims Under the Group Life Waiver of Premium Clause", the Committee analyzed the *experience* of eight large life insurance companies writing this benefit, involving *5,461 claims*, representing $10,085,761 of insurance. (App. E-3) The results of the analysis of this *experience* appear in Table V as follows:

E. RESERVES

Reserves for the first 10 years after approval of disability were computed at 2½% and 3% interest, using the graduated mortality and recovery rates and Hunter's ultimate death rates and appear in Table V. Hunter's ultimate reserves can be used for consistent factors for higher durations. (App. E-11)

TABLE V

Disability Claim Reserves per $1,000 of Insurance Assuming Hunter's Ultimate Mortality Rates after 10 Years

Duration	Experience by Amounts		Experience by Lives	
	2½%	3%	2½%	3%
0	$557	$532	$548	$524
1	567	537	555	527
2	594	560	579	547
3	624	588	608	574
4	654	616	638	601
5	650	641	666	628
6	703	664	691	652
7	724	655	713	675
8	740	702	732	694
9	752	715	745	707
10	760	723	754	716

(App. E-9)

Table V appears in Section II of the 1949 Report and shows that for a disability of zero duration based on *experience* by amount of coverage (at 3% interest), the disability claim reserve is $532 per thousand, ($532/$1,000) graduating each year so that at 10 years of duration of disability, the reserve factor is $723 per thousand ($723/$1,000).

The conclusion reached by the Committee is stated in Section I as follows:

1949 REPORT OF THE COMMITTEE ON GROUP MORTALITY AND MORBIDITY

SECTION I — GROUP LIFE INSURANCE

* * * *

The experience under each of the three common disability provisions is shown separately. Following is a description of these provisions:

(i) The Waiver of Premium Disability Clause, in general, provides for waiver of premium on receipt of proof of permanent total disability in the event that disability occurs before age 60. Total disability is presumed to be permanent after it has continued for nine months and proof of continued total disability is required annually.

The total actual claims for the Waiver of Premium data have been computed by adding to the death claims 75% of the number of approved disability claims. Although there are some indications in the study by the committee described in Section II of this report that a factor somewhat less than 75% may be more in accord with current experience, the factor in this report was maintained on a basis consistent with previous reports because of the smallness and newness of that experience.

(App. E-2, 3)

The Committee recommended that the then current industry practice of charging each group's experience with a claim of 75% of the approved disability claims *(i.e.*, $750/$1,000) was to be continued even though the experience as tabulated in Table V indicated that the appropriate charge, and consequently the reserve to be established, might be somewhat lower. Life reserves are calculated by actuaries on the basis of each $1,000 of life insurance.

The court below held there was no causal relationship between the conclusion of the second paragraph of Section I above and Section II of the report which contained Table V. (App. C-24). However, it did hold that Table V was a recognized mortality and morbidity table under Section 801(b) and that a reserve based on the table was a "life insurance reserve."

Although it rejected Petitioner's use of the widely accepted industry estimate of $750/$1,000, it stated:

> It is clear that, after 1949, there was information available as to the figures needed for computations of disability-disabled reserves. The 1949 Report contained a chart setting forth the specific appropriate reserve amounts based on recognized mortality tables, duration of disability and assumed rates of interest. Id. *Any taxpayer need only consult the table, determine the rate of interest to be used, find the duration of disability for the policy holder and note the appropriate reserve. Id.* (Emphasis added) (App. C-16)

Thus, the court approved the use of Table V even though it contained no age factor and contained no safety margins. All that was required to establish a proper reserve was to

measure the period of disability of each insured against the appropriate reserve factor set forth in Table V and multiply the reserve factor by the amount of total coverage involved per thousand to determine the total required reserve.

The period of disability for Petitioner's 23 insureds was at least six months duration at the end of 1967 since the record in this case indicated that there were no such disabled insureds at the end of 1966. (II R 94) The lowest figure in Table V with respect to experience by amounts is a reserve for $532 per thousand ($532/$1,000) at 3% interest or $557/$1,000 at 2½% interest. Since, as Table V discloses, the reserve factor increases with the period of disability, if Table V is applied to the 23 disabled insureds, having total coverage of $112,000, with the shortest period of disability, Petitioner's reserve would be at least $532/$1,000, resulting in a qualified life insurance reserve of $59,584, which amount is sufficient to qualify Petitioner as a life insurance company since more than 50% of its total reserves would be life insurance reserves.

Although a determination of Petitioner's reserves using Table V would have resulted in Petitioner being taxable as a life insurance company under Section 801, the Court of Appeals concluded as a matter of law that it could not make this determination because Petitioner had initially used the $750/$1,000 industry-wide estimate and not the reserve factor of $532/$1,000 set out in Table V in establishing this reserve. The Fifth Circuit's decision is squarely in conflict with the Court of Claims' decision in *Central National Life Insurance Company of Omaha v. United States*, 574 F2d 1067 (Ct. Cl., 1978) (No Cert (G) 1978 P-H 61,000) (hereafter referred to as *Central National)* and Section 801(b) itself.

REASONS FOR GRANTING THE WRIT

I.

A The decision of the court below that the use of the $750/$1,000 reserve factor did not qualify as a life reserve conflicts with the *Central National* case because the $750/$1,000 reserve factor used by Petitioner in establishing this reserve is a reasonable approximation of the amounts that would have been derived from the tabular computation using Table V of the 1949 Report, or the $750/$1,000 reserve factor used by Petitioner in establishing this reserve included the qualifying lesser amount of $532/$1,000 that could have been derived from a tabular computation using Table V of the 1949 Report.

In *Central National*, as here, the issue was whether the taxpayer qualified as a life insurance company and that issue was to be determined by whether certain of its life reserves qualified under Section 801(b). In that case, rather than computing its credit life reserves in accordance with the mortality table specified in its credit life policy, Central National utilized the gross unearned premium method of estimating those reserves. Here, Petitioner's actuary established a reserve for its 23 disabled insureds of $750 per thousand based on an accepted industry-wide estimate. Both of Petitioner's expert actuaries believed that this industry-wide estimate was approved in the 1949 Report and thus supported by a recognized morbidity table. (III-R-21, 46) Even if they were mistaken, as the court below erroneously determined, the question remains as to whether Petitioner may nevertheless qualify as a life insurance company where a recognized (by the court below) mortality table in evidence in this case (Table V of the 1949 Report) disclosed that at least $532 of the $750 per thousand of the reserve would so qualify and support the $750/$1,000 factor used as a reasonable approximation.

The court below held that because Petitioner's actuaries did not use the precise reserve figures of Table V *ab initio* in making the calculation (*i.e.*, \$532/\$1,000), the court could not, as a matter of law, make such a determination or verification even though it is clear from the record in this case that such a determination would have resulted in Petitioner being qualified to be taxable as a life insurance company for the year 1967 under Section 801. But, this is exactly the determination the Court of Claims made in *Central National* and there is thus a conflict between the Fifth Circuit and the Court of Claims, which should be resolved by this Court.

The Court of Claims in *Central National* made two points that are relevant. In determining whether an estimate qualified as a life reserve, it held that:

> (a) If the tabular computation showed that the estimate was a reasonable approximation to the amounts that would have been derived from computations from the appropriate mortality tables, the estimated life reserve qualified as a life reserve under Section 801(b), or,
>
> (b) If the dollar amount of reserves established by the taxpayer included the lesser amount that could be derived from a tabular computation, then at least the lesser reserve amount was a qualified life insurance reserve under Sec. 801(b).

If it is assumed that the \$750/\$1,000 industry-wide estimate used by Petitioner's actuaries had no connection with the 1949 Report, as was erroneously held by the court below, it was, nevertheless, an estimate of the life reserve required for the waiver of premium benefit for the disabled insureds. When the reserve factors from Table V (which was held to be a recognized mortality table under Section 801(b) by the court below) are applied to the \$750/\$1,000

reserve factor used by Petitioner, such accepted tabular reserve factors show:

(a) That the $750/$1,000 is a reasonable approximation of the amounts that would have been derived from the tabular computation since the unadjusted raw experience data of Table V without a safety margin was $532 for zero disability at 3%, or 71% of the $750/$1,000 factor used.

(b) The dollar amount of the reserves established by Petitioner, in this case $750/$1,000, included the qualifying lesser amount of $532/$1,000 that could have been derived from a tabular computation using Table V of the 1949 Report and this amount when multiplied by the insurance involved would qualify Petitioner as a life insurance company (only $527 per thousand being needed).

That the $750/$1,000 reserve factor used by Petitioner is a reasonable approximation of the amount that would have been derived from a tabular computation is clearly supported by Table V, which using raw experience data produced a minimum reserve factor of $532 per $1,000.

However, no actuary in calculating this reserve would have accepted the unadjusted raw experience data of Table V and because of the "newness and smallness" of the experience data would have required the application of a safety margin of at least 30% and Petitioner's expert actuary so testified in district court. (III R 37) In fact, all recognized mortality and morbidity tables contain safety margins in addition to adequate experience data (see Huebner & Black, Life Insurance, 8th Ed., p. 329, and Robert I. Mehr, Life Insurance Theory and Practice, 1st Ed., p. 695) and a table without such margins would be actuarially unsound. For the manner in which safety margins were used in the well-recognized 1958 Commissioner's Standard Ordinary

Table see Robert I. Mehr, Life Insurance: Theory and Practice (Rev.Ed.) p.582. (App. F-1)

In *Mutual Benefit Life Insurance Company v. Commissioner*, 488 F2d 1101 (C.A.3, 1973), cert. denied 95 S.Ct. 148 (1974), the Third Circuit held that the phrase "recognized mortality and morbidity tables" of Section 801(b) was intended to expand, not restrict, the definition of life insurance reserves and that that phrase could not be construed to exclude additional factors that would make the calculation of the reserve more precise or accurate.

In so holding, the Third Circuit stated:

> In 1942 Congress defined reserves as being based on recognized mortality tables and an assumed rate of interest. The definition was intended to broaden the concept of reserves rather than to restrict it. There is no indication since that time that Congress intended to exclude other factors which would make the calculations of the reserve more precise or accurate.* * *

and

> * * * In the factual context present here, we can perceive no considerations which would require us to adopt a construction of the Act so narrow as to mandate the exclusion of circumstances which would tend to make the calculation of the reserve more exact.

An additional safety margin applied to the raw experience data of Table V would certainly make the calculation of the reserve more "precise and accurate" in this case and would come within the rule enunciated in *Mutual Benefit* and the decision of the court below is also in conflict with that case. The rigid approach of the court below caused it to accept the unadjusted raw experience data of Table V as a recognized table but not a factor of $750/$1,000 that included a safety margin, was an industry-wide estimate (based on industry-wide experience and practice) accepted by the State Insurance Commission and was recommended

by Petitioner's expert actuaries as a more precise and accurate reserve for this risk than the raw experience data of Table V based on only 5,461 claims.

Section 801(b) expressly permits a life insurance reserve to be an amount "computed *or* estimated". Each term was purposely included in the statute and each is to be given meaning. The word "estimated" permits flexibility in method and reasonable approximations in result. See *Central National*. Petitioner's use of the $750/$1,000 reserve factor, even if it is an estimate, comes within the express statutory language of Section 801(b).

The court below refused to apply the rationale of the *Central National* case to the facts of this case and erroneously tried to distinguish that case on the ground that "In *Central National* the question was whether a reserve calculated by applying a percentage of gross unearned premiums qualified as a life reserve." (App. C-31) This was *not* the question involved in that case. The taxpayer's position there, as stated by that court, was (at 1075):

> Plaintiff contends that reserves for its credit life policies, although computed through the gross unearned premium method of computation, for purposes of section 801, are life insurance reserves because they were estimated on a tabular basis. Plaintiff alternatively contends that inasmuch as the reserve actually established on its books and reported in its Annual Statements exceeded the amounts that would have been computed by the tabular method, plaintiff at least is entitled to treat as reserves the lesser included amount that could be derived from a tabular computation.

The Commissioner's position was (at 1075):

> ***Defendant's only position is that reserves so computed do not qualify as life insurance reserves under section 801; that reserves so computed constitute "other reserves required by law"; and that the reserves cannot

be retroactively recomputed pursuant to methods required for life insurance reserves.

If *Central National* had calculated its reserves on the basis of the tabular mortality tables multiplied by 130% (as required by state authorities), the mean reserves would have been $911,010 versus mean unearned premium reserves of $1,292,566 actually established. The Government contended that the $1,292,566 was (at 1082):

> ***not a close approximation of the tabular reserve that would have been required in 1964. Defendant also asserts that plaintiff may not use the Illinois standard that permits credit life reserves be based on 130 percent of the appropriate mortality table.

The Court of Claims in holding that *Central National* qualified as a life insurance company stated (at 1082):

> The dollar amounts that plaintiff reported as its credit reserves were *reasonably approximate* to the amounts that would have been derived from computations from the appropriate mortality tables. The amounts reported satisfy the requirement that the reserve be estimated on a tabular basis. (Emphasis added)

The Court of Claims' decision also held (at 1082):

> In any event, the dollar amount of reserves established by plaintiff on its credit life policies included the *lesser amount* which would have been *derived* from a computation based upon 130 percent of the appropriate table, which, when included in the numerator of the qualification fraction, would also confirm plaintiff's status as a life insurance company in 1964. (Emphasis added)
>
> On the basis of the foregoing, plaintiff's reserves on its credit life policies satisfy the requirements of the statutory definition in section 801(b).***

The citation of the court below, in Footnote 16, to *Pacific Mutual Life Insurance Co. v. Commissioner*, 40 TC 118 (1967), does not prevent the recognition of the reserve in whole or in part as a life reserve. The issue there, as stated by the Tax Court was "Whether petitioner may retroactively adjust its beginning 1958 group accident and health reserves and individual hospital and medical claim reserves for alleged overstatements therein." (At 119) The taxpayer there wanted to reduce those reserves as being overstated but the Tax Court refused to permit such action. Here, Petitioner did not seek to increase or decrease the reserve established, retroactively or otherwise. All that Petitioner seeks is that all or at least a substantial portion ($59,584 or $532/$1,000) of the reserve established as a life reserve be recognized as a life insurance reserve. Here, there is no attempt to change the life reserve actually established as was the issue in the *Pacific Mutual case.*

There is no requirement in the Internal Revenue Code, the Regulations thereto or in any decided case that the portion of the reserve to be recognized as a life insurance reserve has to be precisely *calculated in advance* as suggested in Footnote 16 of the opinion of the court below. The $84,000 reserve was established initially as a life insurance reserve on the basis of long-standing and wide-spread estimation used in the industry. (III-R-10 and App C-19, Footnote 10). The $750/$1,000 reserve factor also was required by state law. (III-R-46) Petitioner's calculation included the lesser amount of $532/$1,000 at 3% interest or $557 at 2½% interest of death benefit as set forth in Table V to the 1949 Report. To that extent, it was calculated, or was capable of being calculated, at the appropriate time. There is no rule of law or equity that precluded the court below from recognizing the sum of $532/$1,000 or $59,584 of the estab-

lished reserve as a life insurance reserve under Sec. 801(b). Since the court below is permitted to draw all inferences from undisputed facts and since the calculation is a mere mathematical computation, there was no judicial mandate which prevented the court below from deciding that $59,584 of the $84,000 qualified as a life reserve and, therefore, Petitioner qualified as a life insurance company for 1967. Failure to do so put the decision of the court below in conflict with the Court of Claims' decision in *Central National*. Alternatively, the court below should have remanded the case to the district court to make such a computation applying the reserve factors of Table V and then determine if Petitioner qualified as a life insurance company for the year 1967. This would be a fair result since the method of calculating this reserve was not free from doubt in 1967.

The court below also stated that *Central National* could not be applied to this case because there was no showing at trial what its reserve would have been if it used the proper tables of the 1949 Report. This is erroneous since everything was in evidence in the case that would have permitted the computation or verification of the reserve. Table V of the 1949 Report was in evidence and the only other evidence necessary to make the computation was the period of disability of each of Petitioner's insureds. We reiterate that Table V required no evidence of age factors since the study contained no age factors. The evidence in the district court indicated that there were no disabled insureds at the end of 1966 so that in 1967 the disabled insureds had a period of disability of zero disability or one year disability. (II-R-94) Even if the shortest period of disability contained in Table V were applied to all of Petitioner's 23 disabled insureds, the reserve by amount could not have been less than $527/$1,000 ($59,020 + $112,000 = $527) the minimum needed

to qualify Petitioner as a life insurance company under Section 801 *under any circumstances.* Under experience by amounts at zero duration of disability, the reserve factor of Table V is $557 at 2½% interest and $532 at 3% interest.

Both of these factors exceed Petitioner's minimum required amount of $527/$1,000. Thus, as the court below itself stated, all that was needed to have been done was to apply the period of disability to the table to produce the reserve. No other proof at trial was necessary as to what the amount of the reserve would be. All that was required was a simple mathematical calculation which the court below refused to make because it erroneously concluded that it was legally without the power so to do. However, the Court of Claims found no such prohibition in *Central National* and thus the decision of the two cases are in conflict and should be resolved by this court.

B The $750/$1,000 reserve factor used by Petitioner's actuary in establishing the reserve for the 23 disabled insureds is an estimate which does qualify under Section 801(b) as amounts "which are computed or estimated on the basis of recognized mortality or morbidity tables."

Petitioner's use of the $750/$1,000 reserve factor for its 23 disabled insureds does qualify under Section 801(b) as amounts "which are computed or estimated on the basis of recognized mortality or morbidity tables." The statutory language now contained in Section 801(b) of "recognized mortality or morbidity tables" was first enacted by the Revenue Act of 1942.

The meaning to be given "recognized mortality or morbidity tables" can be gathered from the Committee Reports under the 1942 Act. The House-passed version of the 1942 Act provided that the reserves were to be based on "recog-

nized experience tables." The House Ways and Means Committee Report No. 2333, 77th Cong., 1st Sess. (1942-2 C.B. 372, 454) discussed the change as follows:

> Section 201(c)(2) is new and defines the term "life insurance reserves." The definition is substantially that contained for many years in the regulations with the addition that the reserves must be based on *recognized experience tables*, the health and accident insurance contracts must be non-cancelable, and unpaid loss reserves on such health and accident contracts are included if computed on a discount basis. (Emphasis added)

In the Senate the language was changed to "recognized mortality and morbidity tables" from the House's "recognized experience tables." This change was described in the Senate Finance Committee Report (1942-2 C.B. 504, 612):

> * * * The use of mortality and morbidity tables instead of experience tables as in the House bill eliminated any possibility of excluding reserves which are based on sound tables *which are not compiled from actual experience.* * * * (Emphasis added)

This quotation from the Senate Report indicates that the phrase "recognized mortality and morbidity tables" as finally adopted is expansive. As in this case, instances can and do arise where neither widely-used mortality or morbidity assumptions nor a company's own experience is adequate, e.g., the development of an entirely new form of benefit. Petitioner submits that in this instance "recognized" does include mortality and morbidity assumptions based on generally accepted actuarial standards or estimates, provided such data is acceptable to state insurance authorities. The legislative history discloses that the word "recognized" as used in Section 801(b) cannot properly be con-

strued to refer exclusively to widely-used or standard tables. Instead, the phrase "recognized mortality or morbidity tables" should properly be interpreted to mean any mortality or morbidity assumptions, viz., either a company's own experience or a widely-used standard or estimate, which are accepted by state insurance authorities, as being proper data for the computation of reserves.

The Third Circuit in *Mutual Benefit* held the phrase "recognized mortality or morbidity tables" was intended to broaden the concept of life reserves. The phrase cannot be construed as to exclude factors which make the reserve more precise. Section 801(b) expressly allows the reserve to be an "estimate."

The $750/$1,000 reserve factor used by Petitioner's actuary to calculate this reserve came from the practice and experience of the nation's actuaries who were called upon to estimate this reserve at a time when there were no recognized tables for computing this reserve for *group* life policies. After the 1949 Report, the nation's actuaries continued this practice because of the newness and the smallness of the unadjusted raw experience data of the 1949 Report (only 5,461 claims). It is also clear that Section I of the 1949 Report recommends that the practice of using the $750/$1,000 reserve factor be continued because of the "newness and smallness" of the experience data of the Report. (App. E-3) Clearly, there is no recommendation in the 1949 Report that the industry rely on the raw unadjusted experience data of Table V (involving only 5,461 claims) as did the court below.

Further, the $750/$1,000 reserve factor used by Petitioner's actuary, which was an estimate based on the experience of the industry, was recognized and approved by

the actuarial industry and most of the states and was accepted and approved by the Texas Insurance Department as the correct manner for reserving for this risk. (III R 46) As such, this reserve thus computed comes within the statutory definition contained in Section 801(b) as explained in the legislative history, *supra.*

This conclusion is reinforced by the decision in *United States v. Consumers Life Insurance Company*, 430 U.S. 725 (1977), where this Court held that when Section 801 was enacted Congress intended to rely on customary accounting and actuarial practices and that in presenting the 1959 legislation to the full House, members of the Committee that drafted the bill were careful to underscore the continuing primacy of state regulations, with specific reference to the question of reserves. This Court there stated that "no state insurance department required any change in the way the taxpayers computed and reported their reserves," and this was true in this case.

The disability reserve here involved was for a new benefit, which first appeared in group policies in 1938, and for Petitioner 1967 was the first year such a reserve had to be established with respect to its 23 disabled insureds. In 1967 when this reserve was to be established there were no "recognized mortality or morbidity tables" in existence to compute or estimate this reserve except for the industry-wide estimate and the 1949 Report. Industry-wide practice among the actuaries was to use a figure of $750/$1,000 and this reserve factor was accepted by the states. The court below held that the 1949 Report was not a recognized mortality or morbidity table except to the extent of the unadjusted raw experience data of Table V. If the 1949 Report is not a recognized mortality or morbidity table, then no such tables existed in 1967 to compute this reserve and the indus-

try estimate of $750/$1,000 accepted by the Texas State Insurance Department should qualify as an estimate based on recognized tables in view of the legislative history of Sec. 801(b). Even the raw experience data of Table V supports the reasonableness of the $750/$1,000 reserve factor where the range from zero period of disability was $532 per thousand and 10 years of disability was $720 per thousand for an average overall reserve factor close to $700. All life reserves are estimates which can be arrived at in a variety of ways and involve actuarial judgment. *Central National.*

The $750/$1,000 produced a qualified life reserve, since in the absence of any recognized tables, it was the best estimate of the actuarial industry and of Petitioner's actuary to reserve for this benefit and was accepted and approved by the Texas Insurance Department and the Court of Appeals' narrow interpretation of Section 801(b), based largely on the testimony of a revenue agent, should be reversed as being contrary to Section 801(b) and its legislative history, this Court's decision in *Consumers Life*, and the 1949 Report.

II.

The court below erred in holding that oral demands supported by written documents submitted by Petitioner and allowed by the Revenue Agent and the Commissioner in 1967 were not informal claims for refund within the meaning of Section 6511, IRC.

STATEMENT OF THE CASE

The opinion of the court below stated:

> There is no indication from the record that Group Life had previously sought a refund — either formally or informally — of the taxes paid with its return on the basis of the additional deductions. (App. C-35)

and

> * * * no action on the part of the Commissioner indicates that he considered and treated Group Life's course of conduct prior to the deficiency determination as an informal claim for refund. (App. C-37)

These statements are contrary to the record established in this case before the district court on Petitioner's motion for judgment, which record the court below ignored. That record, consisting of affidavits of Royston Kennedy (II-R-344-441) and O. Jan Tyler (II-R-442-516), together with various exhibits, shows that Petitioner affirmatively presented to Revenue Agent Strickland at the beginning of his examination claims for additional deductions which, if allowed, would result in a refund. Based on these affidavits and documents, the district court made the following Findings of Fact:

> * * * Group Life made timely informal claim for the adjustments unrelated to life insurance company status. The merits of these unrelated claims were considered and accepted by the IRS to fully allow their inclusion as deductions. Consequently, the IRS cannot now raise the bar of that limitations section to argue that formal claim was not timely filed; the Commissioner effectively waived requirement of a formal claim when he disposed of their substance on the merits to ascertain that Group Life had overpaid by an amount attributable to these unrelated deductions.
>
> (II-R-552-554) (App. B-2)

The proper question before the court below was whether the findings of the district court were clearly erroneous based on the affidavits and documents which are part of the record (II-344-516) in this case. However, the opinion of the court below does not even address that issue because it is stated "* * * it appears from the record that no informal

or formal claim for the refund of the additional amounts at issue was ever made by Group Life to the Commissioner." (App. C-35) The court's opinion leads the reader to believe that the additional deductions were allowed by the Commissioner *sua sponte* without any action on the part of Petitioner. The record developed before the district court is totally contrary to such a factual statement.

The affidavit of Petitioner's comptroller, Royston Kennedy, stated:

> (6) On or about January 16, 1969, Revenue Agent J. R. Strickland commenced an examination of Group Life's 1966 and 1967 income tax returns. The 1967 income tax return was filed on September 16, 1968, with a total payment for income taxes of $618,053.57.
>
> (7) On January 16, 1969, Revenue Agent Strickland requested from the undersigned numerous documents which were recorded by the undersigned on Exhibit C attached hereto. Each one of these documents were obtained and submitted to Revenue Agent Strickland.
>
> (8) In the course of Revenue Agent Strickland's examination of the 1966 and 1967 income tax returns, *the undersigned had discussions with Revenue Agent Strickland* regarding the results of the adjustments made by Revenue Agent Hamilton in the examination of the 1965 income tax return, which would result in additional adjustments reducing Group Life's taxable income for the years 1966 and 1967. Further, the position taken by the Texas Insurance Department regarding the policyholders' dividends *was also explained to Revenue Agent Strickland*, the details of which were fully set forth in the examination report dated December 10, 1968, a copy of which is attached hereto as Exhibit D.
>
> (9) *Revenue Agent Strickland agreed with the undersigned that two adjustments were in order for both the*

year 1966 and the year 1967 as a result of Revenue Agent Hamilton's determinations in 1965. Those adjustments called for reducing premium income on the group life policies and allowing a deduction for 10% of the 1965 reserve strengthening. Revenue Agent Strickland, however, disagreed that Group Life was entitled to a deduction for the accrual of the $749,163.45 liability for dividends to policyholders as required by the Texas Insurance Department for the year 1966. *Revenue Agent Strickland did agree, however, that a deduction for those dividends was allowable in the year they were paid, which was the year 1967.* (Emphasis added)

(II-R-344-441)

The affidavit of Petitioner's attorney also stated:

(2) On February 20, 1969, Mr. Sands and the undersigned had a conference in the A.M. with Revenue Agent Strickland and Royston Kennedy regarding Revenue Agent Strickland's examination of Group Life's 1966 and 1967 Federal income tax returns. At that meeting, Revenue Agent Strickland delivered his undated proposed Revenue Agent's Report (a copy of which is attached to the Affidavit of Royston Kennedy, filed simultaneously herewith, as Exhibit E) and explained all of his adjustments that he was proposing to Group Life's tax returns for both years, including proposing to allow additional reductions in taxable income for 1967 by reducing premium income for group life policies, allowing a deduction for amortization of the 1965 reserve strengthening, an additional deduction for dividends actually paid to policyholders, and additional deductions for depreciation resulting from his capitalization of general expenses. The undersigned advised Revenue Agent Strickland that Group Life would not dispute and *would accept the additional allowable reductions of taxable income.* (Emphasis added)

(II-R-442-516)

ARGUMENT AND AUTHORITIES

At the very beginning of the examination of the 1967 tax return, Revenue Agent Strickland was advised that Petitioner was entitled to the additional four deductions for 1967 which had not been claimed in the return for the year 1967 and, if these additional deductions were allowed, Petitioner was entitled to a refund of taxes it had paid with the return. It was only after these claims were made, and the supporting documents submitted, that Revenue Agent Strickland advised Petitioner's representatives and officers that the additional deductions were being allowed. Thereafter, the Internal Revenue Service *allowed* these additional deductions in its 30-day letter and in its statutory notice (90-day letter). The record shows that all of these actions by the Commissioner and his duly authorized agent were performed within the statutory period allowed by Sec. 6511. In view of the fact that these four deductions were *expressly allowed* by the Examining Agent and the Commissioner in the 90-day letter, how can it be said that they were never claimed? The Commissioner was fully apprised not only of all four grounds upon which Petitioner was making claim but of the complicated factual basis of such claims. The Commissioner well knew of the grounds, the factual basis thereof, so that he *clearly allowed* these substantial amounts. He knew Petitioner was asking for a refund of the taxes attributable to those deductions and Petitioner would have received a refund of the $147,345.06 without any other action on its part. Thus, the claims submitted by Petitioner's Comptroller Kennedy "set forth in detail each ground upon which a credit or refund is claimed and facts sufficient to apprise the Commissioner of the exact basis thereof," as required by Treas. Regs., Sec. 301.6402-2(b).

In fact, the Commissioner took the amount of tax that would have been refunded and offset it against the tax resulting from the life insurance company issue, thereby reducing the amount of that deficiency. The offset was not a rejection of the four claimed deductions but a continuing recognition of the allowance since only an allowance could be used as an offset. The Commissioner was authorized by Sec. 6402(a) to credit the amount of any overpayment "against any liability in respect of an internal revenue tax on the part of the person who made the overpayment. * * *" Once the offset was made pursuant to Sec. 6402(a), the only way Petitioner could recover the amount attributable to the four allowed deductions was to file a claim for refund on the life insurance company issue and thereafter file this lawsuit.

The claim for refund on the life insurance company issue provided for a claim for refund of $466,925.38 "plus such other amounts as may be legally refundable." This claim was attached to the complaint and incorporated by reference in Paragraph 4 thereof.

This Court has previously held on many occasions that claims for refund can be informal and arise through conferences and negotiations with revenue agents. See *Bonwit Teller & Co. v. United States*, 283 U.S. 258 (1931), and *United States v. Kales*, 314 U.S. 196 (1941), and cases cited. In *Angelus Milling Company v. Commissioner*, 325 U.S. 293 (1945), this Court held that such an informal claim exists if the Commissioner dispensed with formal requirements and examined the merits of the claims. All that is required is that the evidence should be clear that the Commissioner understood the specific claim that was made even though there was a departure from form in its submission. In so holding, Justice Frankfurter speaking for the Court stated:

> * * * If the Commissioner chooses not to stand on his own formal or detailed requirements, it would be making an empty abstraction, and not a practical safeguard, of a regulation to allow the Commissioner to invoke technical objections after he has investigated the merits of a claim and taken action upon it. Even tax administration does not as a matter of principle preclude considerations of fairness.

The regulation referred to in the above opinion is Treas. Reg. Sec. 301.6402-2(b), which provides in part that the claims submitted "set forth in detail each ground upon which a credit or refund is claimed and facts sufficient to apprise the Commissioner of the exact basis thereof." As this Court stated in *United States v. Memphis Cotton Oil Company*, 288 U.S. 62 (1933), "The function of this regulation is to facilitate research.", and in *Tucker v. Alexander*, 275 U.S. 228 (1927), "The statute and regulations must be read in the light of their purpose. They are devised, not as traps for the unwary, but for the convenience of government officials in passing on claims for refund * * *." Detail of each ground was submitted by Petitioner to the Commissioner in this case with sufficient facts so that the Commissioner did investigate and research the merits of the four complicated claims and took action on the claims by fully allowing them as deductions in the Revenue Agent's 30-day letter and in the Commissioner's statutory notice (90-day letter) and used these four allowed deductions to reduce the deficiency caused by the life insurance company issue.

The decision of the court below has allowed the Commissioner to raise the "technical objection" of the statute of limitations after the Commissioner has investigated the merits of the claims for the four deductions and taken action upon them by allowing them contrary to the above stated

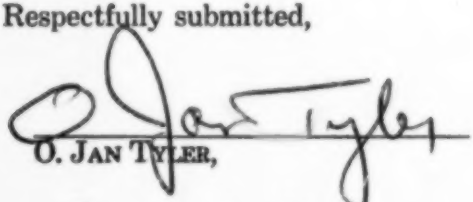
rule of *Angelus Milling Company* and other cases decided by this Court.

Finally, the anomalous result of the decision of the court below on this issue is that Petitioner will receive the benefit of these four deductions for the year 1967 if it loses the life insurance company issue (because these items have been allowed) but will not receive these benefits for that year if it wins the life insurance company issue. This result shows that the court below incorrectly decided this issue.

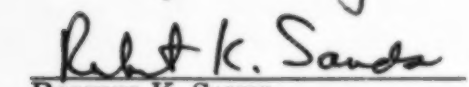
CONCLUSION

The petition for Writ of Certiorari should be granted.

Respectfully submitted,



O. JAN TYLER,



ROBERTS K. SANDS,

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Appendix

Appendix A

¶ 78-5353

GROUP LIFE & HEALTH INSURANCE COMPANY, PLAINTIFF v. U.S., DEFENDANT. U.S. District Court, Northern Dist. of Texas, Dallas Div., Civil No. CA-3-8014-F, Oct. 20, 1978. Year 1967. Decision for taxpayer.

1. *LIFE INSURANCE COMPANIES — Basic rules — definitions — life insurance reserves.* Taxpayer net 50% reserve test and qualified as a life insurance co. under Sec. 801(b). With the addition of taxpayer's Reserve for Disability-Disabled Lives, which had been estimated on the basis of a broader-based 1949 report by the Society of Actuaries, taxpayer's life insurance reserves exceeded 50% of its total reserves. *Reference:* 1978 P-H Fed. ¶29,112(20). Sec. 801.

O. Jan Tyler, Robert K. Sands, Sands & Tyler, 2030 Republic Bk. Tower, Dallas, Tex., Attys. for Plaintiff.

Frank D. McCown U.S. Atty., Martha Joe Stroud, Asst. U.S. Atty., William W. Guild, Howard A. Weinberger, Attys., Tax Div., Dept. of Justice, 1100 Commerce, Dallas, Tex., for Defendant.

PORTER, District Judge:

Findings Of Fact And
Conclusions Of Law

The Court adopts and enters the following Findings of Fact and Conclusions of Law:

Findings of Fact

1. This is a civil action for the recovery of Federal income taxes and interest paid by Plaintiff Group Life & Health Insurance Company (hereinafter referred to as Group Life) for the calendar year 1967. Group Life has complied with all

jurisdictional requirements necessary to maintain this action and jurisdiction over the subject matter is vested in this Court pursuant to 28 U.S.C.A. Sec. 1346(a)(1).

2. Group Life timely filed its Federal income tax return for the year 1967 and paid the amount of tax shown to be due thereon. After examination of the tax return by agents of the Internal Revenue Service, the Commissioner of Internal Revenue assessed a deficiency for income taxes for the year 1967 in the amount of $466,925.83, which amount was paid by Group Life on November 22, 1971, plus interest. (Stip. Par. 7)

3. Group Life timely filed a claim for refund for the additional taxes and interest paid, which claim for refund was disallowed by statutory notice dated December 10, 1973. (Stip. Par. 8)

4. The question in this case is whether Group Life computes its tax liability for the year 1967 as a life insurance company under Sec. 801 of the Internal Revenue Code of 1954 and this question is determined by whether its life insurance reserves, plus its reserves for unearned premiums and unpaid losses on noncancellable life, health and accident policies not included in the life insurance reserves, comprised more than 50% of its total reserves for the year 1967.

5. The Commissioner determined that Group Life was not a life insurance company for tax purposes during the taxable year 1967 since he computed its ratio of life reserve to total reserves to be 48.4335% in the following manner:

Group Life And Health Insurance Company

Computation To Determine Whether Or Not Company Qualifies As A Life Insurance Company
1967

Reserve	1966	1967	Mean
Ordinary Life-1958 CSO 3% CRVM	96,664.73	148,498.50	
Ordinary Life-1958 CSO 3½% Net Level	1,308,227.00	1,751,369.20	
Group Life-1941 CSO 3% CRVM	1,352,007.28	1,740,125.29	
-Less: 2% of Premiums Since Inception[1]	(82,928.12)	(118,381.94)	
-1958 CSO 3% CRVM		6,794.19	
Annuities		1,807,916.00	
Total Life Reserves, Net of Policy Loans	2,669,534.51	5,326,188.61	3,997,861.56
Total Reserves:			
Life Reserves, As Above	2,669,534.51	5,326,188.61	
Accidental Death	9,297.06	62,577.57	
Disability-Active Lives	25,413.10	63,856.72	
Disability-Disabled Lives	2,607.00	88,958.00	
Fractional Premiums	23,496.68	7,385.50	
Unearned Premiums-Group A. & H.	734,124.59	692,941.42	
Unpaid Claims-Group A. & H.	4,133,857.02	2,619,917.57	
Unpaid Claims-Ordinary Life	19,700.00	28,800.00	
Total Reserves, Net of Policy Loans[2]	7,618,029.96[3]	8,890,625.39	8,254,327.68

Ratio Life to Total Reserves = 3,997,861.56 ÷ 8,254,327.68 = 48.4335%

(1) Does not qualify as a life reserve.

(2) Does not include reserve for unpaid claims-Group Life.

(3) Does not include reserve for unpaid claims-Group Life or reserve for the immediate payment of death claims in the amount of $17,798.06 at 12-31-67.

Since the mean of the net life reserves is less than 50% of the mean of net total reserves, the company does not qualify as a life insurance company under Sec. 801(a).

(Stip. Ex. D)

6. Group Life claimed that it qualified as a life insurance company under Sec. 801(a) for the year 1967 because:

(a) the Reserve for Fractional Premiums, Reserve for Immediate Payment of Death Claims, Reserve for Accidental Death Benefits, Reserve for Disability-Active Lives and Reserve for Disability-Disabled Lives listed in Exhibit 8 to Group Life's Annual Statement for 1966 and 1967 were life insurance reserves within the meaning of Sec. 801(b) of the Internal Revenue Code and, therefore, should have been included in the numerator of the qualifying fraction in determining whether Group Life qualified as a life insurance company, and, alternatively,

(b) that unpaid losses were overstated for the year 1967 since —

(i) the amount of claims paid on its behalf from its own funds by Group Life's agent, its parent corporation Group Hospital Services, Inc., or its affiliate, Group Medical & Surgical Services, Inc., on December 31, 1966, in the amount of $545,072.00 and on December 31, 1967, in the amount of $1,231,311.39 were not includable as unpaid losses in determining whether Group Life quali-

fied as a life insurance company since the act of an agent in paying such losses (out of a principal's funds) was the act of the principal and Group Life's reserve for unpaid losses should not include claims already paid by its agent (Superior Life Insurance Company v. United States, 462 F.2d 945 [29 AFTR 2d 72-1370] (C.A. 4, 1972));

(ii) but, if such offset is not correct and the payable and receivable should be shown on the balance sheet, the payable is not an unpaid loss reserve but is an intercompany accounts payable from Group Life to Group Hospital and Group Medical and, as such, not to be included in the reserve for unpaid losses at both such dates;

(iii) that, if the unpaid loss reserve for life policies is to be excluded from both the numerator and denominator of the qualifying fraction because said claims are fixed accrued liabilities as the Defendant has claimed, then that theory should also be extended to accident and health claims which were fixed accrued liabilities at the end of 1966 and 1967 to exclude said amounts from the total reserve denominator;

and, alternatively,

(c) that reserves for unpaid losses for individual life insurance contracts and group life insurance contracts maintained by Group Life for the year 1967 are to be included in both the numerator and the denominator in applying the reserve ratio test in determining its status as a life insurance company for tax purposes under Sec. 801(a) (Alinco Life Insurance Company v. United States, 373 F.2d 336 [19 AFTR 2d 745] (Ct.Cl., 1967)).

Since the Court has decided that all of the reserves set out in this Paragraph 6(a) qualify as life insurance reserves under Sec. 801(b) and, therefore, Group Life qualifies as a life insurance company for the year 1967, it does not

decide the alternative claims of Group Life in Paragraph 6(b) and Paragraph 6(c) hereinabove.

7. Group Life is a corporation organized under the Texas Insurance Code and it is authorized to issue insurance policies covering life, health and accident benefits. Its principal place of business is located in Dallas, Texas. It is a wholly owned subsidiary of Group Hospital Services, Inc., a Texas non-profit corporation, hereinafter called Group Hospital, and is also affiliated with Group Medical & Surgical Services, Inc., a mutual assessment company. (Stip. Par. 9)

8. All three companies operate under the Blue Cross-Blue Shield trademark in the State of Texas only, with Group Hospital writing hospitalization insurance and Group Life writing medical-surgical insurance, as well as life insurance, group term insurance and group disability insurance to insured groups in the State of Texas. (Stip. Par. 9) The companies maintained common offices and employees. (Tr. 47, 50)

9. The Reserve for Fractional Premiums, Reserve for Immediate Payment of Death Claims, Reserve for Accidental Death Benefits, Reserve for Disability-Active Lives and Reserve for Disability-Disabled Lives are supplementary reserves listed in Exhibit 8 to Group Life's Annual Statement for 1966 and 1967 and are computed and set aside to reflect properly the liabilities that will accrue in the future for additional types of coverage provided with the basic life insurance policies. These reserves arise under level premium life insurance policies. (Tr. 63)

10. The Reserve for Fractional Premiums is established to correct an erroneous assumption used in computing the basic life policy reserve. In computing life insurance reserves, the tables provide certain reserve factors for various kinds of insurance contracts and the assumption is made in these tables that premiums on those life insurance policies are collected annually in advance for the full policy year. In fact, this is generally not the case since most often life insur-

ance premiums are, in fact, paid monthly. Therefore, the basic life policy reserve contains a minor error and most insurance companies set up a fractional premium reserve, which recognizes that in the year in which the insured dies the company will not collect the entire annual premium. Since most premiums are paid on a monthly basis, there is a loss of almost half of an annual premium in the year of death since it is reasonable to assume that death occurs approximately in the middle of the policy year. To compute the reserve for the fractional premiums, it is customary to sort the policies according to the mode of payment and compute as a function of the basic policy reserve that part of the premium that is not collected in the year of death. (Tr. 64-65)

11. The Reserve for Immediate Payment of Death Claims comes about because the life insurance proceeds are paid immediately upon death, whereas, the basic life reserve contains the assumption that death occurs and the proceeds are paid only at the end of the policy year. Again, in fact, most deaths do not occur at the end of the policy year and the company pays the proceeds upon proof of claim; therefore, assuming that deaths occur in the middle of a given policy year on the average, an insurance company has a loss of interest of approximately half a year on the death proceeds in the year of the death of the insured. This additional reserve for immediate payment of claims is set up to compensate for that inaccurate assumption in the basic life reserves. (Tr. 65)

12. Both the reserve for fractional premiums and the reserve for the immediate payment of death claims are reserves that are a function of the regular active life reserve of the basic life policy. (Tr. 66) Both of the above reserves are very small items in comparison to the total reserves of Group Life. They are computed from formulas found in various actuarial literature that are used to formulate the amount of reserves that are used to cover the amount of these two liabilities. Generally, they are estimated rather

than actually computed for economic reasons. (Tr. 67) If the recognized tables were published correcting these assumptions, or made the correct assumptions, that is, all the premiums are not collected in the year of death and death claims are paid when incurred and not at the end of the policy year, then these two reserve figures would have been included in the basic life reserve. In other words, they would have been a part of the life insurance reserve and would not be set out separately as supplementary reserves. (Tr. 68)

13. The Reserve for Accidental Death Benefits is a supplementary reserve which results from an additional death benefit that was involved in the policies issued by Group Life to the Baptist Annuity Board of the Southern Baptist Convention. Those policies contained an additional benefit in the event that the insured died accidentally, whereupon Group Life would pay twice the amount normally payable. Inasmuch as the accidental death benefit was an extra benefit in the policy and was paid for on a level premium basis, an additional reserve was needed over and above the basic life insurance reserve to cover that liability. The reserve was calculated on the basis of the 1959 Double Accident Table, combined with the 1958 CSO table at 3%. This reserve is computed in the same manner and is of the same type as the basic life reserve and is maintained in addition to the unearned premium reserve. (Tr. 69)

14. In the reserve for accidental death benefits is an item of unearned premium in the amount of $13,224.08. This represents the amount of premium that had been collected by the company at the time the 1967 Annual Statement was prepared. These were paid premiums for a period of time extending beyond the end of the calendar year and, thus, premiums which had not in fact been earned by the company as of the end of the calendar year. The total premiums have been paid but, in preparing the annual statement, it is recognized that only a portion of the total premiums had been earned and this figure makes that adjustment. This reserve is maintained for a noncancellable accident and health insurance contract. (Tr. 70)

15. The Reserve for Disability-Active Lives for the year 1967 consisted of an unearned premium reserve in the amount of $23.28 and an actuarial reserve in the amount of $63,833.44 based on the 1952 disability study and the 1958 CSO-3%. These reserves are required because of a benefit in the basic life policies which provides for the waiver of the premium in the event the insured becomes disabled. After a six-months waiting period, if the insured is disabled and unable to perform his occupation, the policy was automatically kept in force and no premium was required to be paid by the insured for the duration of his disability. This was an extra benefit over and above the basic life benefit of the policy. Premiums were paid by the policyholder on a level basis and reserves were needed to cover these future claims for the continuation of the policy without premium payment in the event of the disability of an insured. This was a basic policy benefit of the same type as the accidental death benefit. This reserve was necessary because the premium remained level, while the risk was increasing by duration since the incident of disability increases with age. (Tr. 72)

16. The Reserve for Disability-Active Lives was computed on the 1964 Commissioner's Disability Table combined with the 1958 CSO-3% table, which is the standard table for computing reserves for life insurance policies. The 3% refers to the interest assumption and the net level refers to the method itself of computing reserves. (Tr. 72-73) This reserve is the same type of actuarially computed reserve as the active life reserve on the underlying life policy. (Tr. 73)

17. In 1967 the $88,958 figure shown in Exhibit 8 under Disability-Disabled Lives consisted of two parts. One part was $4,958 and the other part was $84,000. The $84,000 is the part which relates to disabled individuals under the company's group term life insurance contracts. The $4,958 relates to individual life policies and was computed on the bases of the 1952 Disability Study and the 1958 CSO-3% table. (Tr. 76-77)

18. Group Life computed or estimated the $84,000 reserve by using a reserve factor of $750 for each $1,000 of basic death benefit based on the recommendations of the 1949 Report of the Committee on Mortality and Morbidity published by the Society of Actuaries (hereinafter referred to as the 1949 Report). The need for the reserve arose in 1967 under Group Life's group term life insurance policies which provided for the waiver of premiums with respect to group life policyholders who had been disabled for at least six months. For the year 1967 Group Life had approximately 23 individuals whose premiums were being waived under these group life policies because of disability and it was this group for whom a reserve had to be established.

The function of the Reserve for Disability-Disabled Lives is to fund liabilities of Group Life resulting from increased risks as a result of incurred disability. The individuals for whom these reserves were set aside in each of those years had already become disabled and their premiums were being waived pursuant to the provisions of the group life policy. The disabled insured's life expectancy is substantially shorter than a normal, healthy insured. Although an amount is included in the basic life reserve for the underlying life policy, the Reserve for Disability-Disabled Lives is set up to recognize that a liability exists for a risk which is far greater than the risk recognized under the basic policy. The assumption is that since the individual is totally disabled, there is a very good chance that the insurance company is going to incur a claim on that individual in the near future. Consequently, the basic life reserve is not adequate for that additional risk and the Reserve for Disability-Disabled Lives is designed to provide a reserve to cover that additional risk. Mr. Charles Connolly, Group Life's expert actuary, testified that the active life reserve for the 22-23 disabled individuals at the end of 1967 would have been only $8.80 per $1,000 of coverage since the active life reserve was only about 40¢ per $1,000 (Tr. 119) The reserve is small because the group term contract provides only life insurance protection and does not have guaranteed cash values and may not be continued past its stated term.

However, once an insured becomes disabled, the premium is waived as long as the disability persists, even though the group term life contract may not be renewed. Thus, the company, once an insured becomes disabled, must set up a reserve to recognize the substantial increased liability exposure which is not provided for in the active life reserve. (Tr. 73-75) The Disability-Disabled Lives Reserve is a reserve that needs to be established to properly reflect Group Life's liability with respect to increased exposure as a result of disabled policyholders and, therefore, is an amount under Sec. 801(b) which is set aside to mature or liquidate future unaccrued claims arising from life policies.

19. The 1949 Report is a recognized mortality and morbidity table based on assumed rates of interest. The $750 per $1,000 used by Group Life in calculating the Disability-Disabled Lives Reserve originated in the 1949 Report. The 1949 Report was prepared by the Committee on Group Mortality and Morbidity of the Society of Actuaries. The Society of Actuaries is a nationwide organization, including Canada, and is widely recognized as an organization that has unusual expertise in actuarial matters and is called upon by insurance companies and state regulatory agencies to prepare tables from time to time. This Committee had been continuously studying over a number of years the problem of establishing a reserve for group mortality and morbidity where premiums are waived because of incurred disability under group life policies such as are involved in the instant case. The reserve problem studied by the 1949 Report was exactly the same reserve problem faced by Group Life for the year 1967 with respect to its 23 disabled insureds - namely, how to properly reserve for group term life insurance contracts resulting from increased risk as a result of an incurred disability where there is a waiver of premium clause. The basic assumption of the 1949 Report is that there is an increased risk under these circumstances for which an additional reserve needs to be provided. Part II of the 1949 Report was subtitled "Disability Claims Under The Group Life Waiver of Premiums Clause" (found at

pp. 19-25 of the 1949 Report of the Committee on Group Mortality and Morbidity published by the Society of Actuaries) and contained the following introduction:

> Early in 1938, most companies writing group life insurance adopted a disability clause for new policies which provided for the waiver of premiums during disability on receipt of proof of permanent total disability occurring before age 60. Under this provision, total disability is presumed to be permanent after it has continued for nine months, but proof of continued total disability is required annually. This report presents a study of disability claims approved under the Waiver of Premium Disability Clause through December 31, 1948. The total experience involves 5,461 claims representing a total of $10,085,761 of insurance.

20. The 1949 Report, which formed the basis of the $750 factor, takes into account the probability of recovery, the probability of death, and an assumed interest rate of 3%. The $750 factor is the average reserve, applying the assumed disability to these reserve tables, and assuming an average time of disability to be four or five years. (Tr. 112) Once an insured becomes disabled, his age becomes relatively unimportant and his lifetime is particularly shortened when you have a disability provision requiring disability of six or nine months before becoming effective. (Tr. 113) The committee established a multiple decrement table using the disabled lives and applying rates of recovery and rates of death and developed a reserve based on a single premium life policy that is paid upon the death of a disabled insured but not paid after recovery. (Tr. 126)

21. In the 1949 Report an average age was used to determine the proper reserve factor. An assessment was made of the ages at which the individuals became disabled and the duration of their disability to arrive at a reserve factor that would be appropriate to measure the overall risk. (Tr. 77) This reserve is the same as the active lives reserve and

the other reserves involved herein, which represent funds set aside to fund future unaccrued claims, except that the Reserve for Disability-Disabled Lives relates to a liability which is "in progress" since, as a result of the disability, the insured has moved into a different risk category. (Tr. 78-80)

The reserve computation for the group life policies uses one reserve factor with an interest factor of 3% for all ages rather than having a different reserve factor for each particular age of its disabled insureds because studies have shown that age is not a significant factor once an individual is disabled. In fact, the 1949 Report revealed there were no disabled insureds with more than ten years of disability. When an individual is actually disabled, his current health condition tends to override the basic differential is expected mortality because of age and condition of disability itself becomes the determining factor in assessing the risk involved. In other words, age is not material in an individual who is totally disabled. (Tr. 77)

22. After taking into account the above factors, the Committee on Group Mortality and Morbidity of the Society of Actuaries determined and recommended that a proper reserve for such disabled individuals would be $750 for each $1,000 of basic death benefit and made the following statement:

> (i) The Waiver of Premium Disability Clause, in general, provides for waiver of premium on reecipt of proof of permanent total disability in the event that disability occurs before age 60. Total disability is presumed to be permanent after it has continued for nine months and proof of continued total disability is required annually.
>
> The total actual claims for the Waiver of Premium data have been computed by adding to the death claims 75% of the number of approved disability claims. Although there are some indications in the study by the committee described in Section II of this report that a factor somewhat less than 75% may be more in accord with

current experience, the factor in this report was maintained on a basis consistent with previous reports because of the smallness and newness of that experience. (Page 1, of the 1949 Report)

The 1949 Report is the basis of the use of a reserve factor of $750 for each $1,000 of basic death benefit with respect to incurred disability under group term life insurance policies where premiums have been waived and Group Life's actuary used the factor of $750 for each $1,000 of basic death benefit in determining the $84,000 Reserve for Disability-Disabled Lives for the 23 disabled individuals insured under its group term life insurance policies for the year 1967. (Tr. 76)

23. Connolly, Group Life's actuary expert, testified that a study becomes a recognized table of mortality and morbidity through recognition and usage and, in this particular instance, the study was of such a nature from the standpoint of the number of lives involved and the approach used by the committee in calculating the table that not only did the group actuaries of the principal group underwriting companies recognize it as a standard, but it also has been accepted by most of the states. (Tr. 124) He further testified that 90% to 95% of the group actuaries use the $750 reserve ratio factor in establishing the reserve for disability-disabled lives for group policies. (Tr. 127) This testimony was not contradicted by the Defendant's top actuary, who was present in the courtroom and heard all of the Connolly's testimony. In fact, in 1967 when Group Life's actuary was computing the Reserve for Disability-Disabled Lives on group coverage, he used the *only* table in existence and the 1949 Report was a well recognized table in the life insurance industry. The procedure that Group Life's actuary used was in general use throughout the industry and was required and approved by the Texas Insurance Department. (Tr. 124)

24. The 1949 Report itself was based not only on actual experience of large group underwriters but took into account other recognized tables of mortality and morbidity and

utilized assumed rates of interest. The 1949 Report itself meets all of the requirements as set forth in the definition of a life insurance reserve under Sec. 801(b)(1)(A) since it is a recognized mortality and morbidity table based on assumed rates of interest. The $84,000 Reserve for Disability-Disabled Lives was computed or estimated on the basis of a reserve factor of $750 for each $1,000 of basic death benefit which had its origin in the 1949 Report and, thus, said reserve qualifies as a life insurance reserve. (Tr. 76)

25. Group Life and other insurance companies in the State of Texas are required to maintain reserves that properly reflect their liabilities to their policyholders. The Texas Insurance Code and the Texas Department of Insurance require that all insurance companies doing business in Texas fairly and adequately present their assets and liabilities, and all of the reserves discussed herein under this general requirement are required by Texas Law. (Tr. 86)

26. At the time Group Life's actuary was computing the Reserve for Disability-Disabled Lives, he was not aware that the life insurance company tax status in this case might turn on this reserve. (Tr. 141)

27. The five supplementary reserves; namely, Reserves for Fractional Premiums, Immediate Payment of Death Claims, Accidental Death Benefits, Disability-Active Lives and Disability-Disabled Lives, are amounts which are computed or estimated on the basis of recognized mortality and morbidity tables and assumed rates of interest and which are set aside to mature or liquidate future unaccrued claims arising from life insurance and which are required by state law.

Conclusion of Law

1. This Court has jurisdiction of the subject matter pursuant to 28 U.S.C.A. Sec. 1346(a)(1).

2. Sec. 801(a) of the Internal Revenue Code defines a life insurance company for tax purposes to be an insurance company whose life insurance reserves plus unearned pre-

miums and unpaid losses on noncancellable life, health or accident policies not included in life insurance reserves comprise more than 50% of its total reserves. Total reserves are defined in Sec. 801(c) to be life insurance reserves, unearned premiums and unpaid losses not included in life insurance reserves and all other insurance reserves required by law.

3. Life insurance reserves are defined in Sec. 801(b) as follows:

Sec. 801. Definition Of Life Insurance Company.

(b) Life Insurance Reserves Defined. —

(1) *In general.* — For purposes of this part, the term "life insurance reserves" means amounts —

(A) which are computed or estimated on the basis of recognized mortality or morbidity tables and assumed rates of interest, and

(B) which are set aside to mature or liquidate, either by payment or reinsurance, future unaccrued claims arising from life insurance, annuity, and noncancellable health and accident insurance contracts (including life insurance or annuity contracts combined with noncancellable health and accident insurance) involving, at the time with respect to which the reserve is computed, life, health, or accident contingencies.

(2) *Reserves must be required by law.* — Except —

(A) in the case of policies covering life, health, and accident insurance combined in one policy issued on the weekly premium payment plan, continuing for life and not subject to cancellation, and

(B) as provided in paragraph (3), in addition to the requirements set forth in paragraph (1), life insurance reserves must be required by law.

* * * * *

(5) *Amount of reserves.* — For purposes of this subsection, subsection (a), and subsection (c), the amount

of any reserve (or portion thereof) for any taxable year shall be the mean of such reserve (or portion thereof) at the beginning and end of the taxable year.

[1] 4. On brief the Defendant conceded that Group Life's Reserves for Fractional Premiums, Immediate Payment of Death Claims, Accidental Death Benefits, Disability-Active Lives and $4,958 relating to individual life policies of the Reserve for Disability-Disabled Lives were life insurance reserves within the meaning of Sec. 801(b). The Defendant did, however, contend that $84,000 of the Reserve for Disability-Disabled Lives was not a life insurance reserve. The issue to be resolved is whether the $84,000 Reserve for Disability-Disabled Lives and the other reserves mentioned above established by Group Life for the year 1967 qualify as a life insurance reserve pursuant to Sec. 801(b), supra. For the $84,000 Reserve for Disability-Disabled Lives and the other reserves to qualify under Sec. 801(b) as life insurance reserves, they must be (1) an amount computed or estimated on the basis of recognized mortality and morbidity tables and assumed rates of interest, (2) an amount which is set aside to mature or liquidate future unaccrued claims arising from life insurance, and (3) required by law. This Court has found as a fact and concludes as a matter of law that Group Life's $84,000 Reserve for Disability-Disabled Lives and Reserves for Fractional Premiums, Immediate Payment of Death Claims, Accidental Death Benefits, Disability-Active Lives and the $4,958 relating to individual life policies of the Reserve for Disability-Disabled Lives are life insurance reserves meeting all of the requirements of Sec. 801(b), and, therefore, all of such reserves are to be included in the numerator of the qualifying fraction under Sec. 801(a). Group Life is, thus, taxable as a life insurance company pursuant to Sec. 801(a) since the mean of its life insurance reserves as defined by Sec. 801(b) comprise more than 50% of its total mean reserves for the year 1967.

5. There is no way to arrive at a single "correct" number for a life insurance reserve since every company's life

reserve basically is only an estimate. Here, Group Life properly availed itself of the broader experience of the 1949 Report (5,461 individuals), which it used to arrive at an estimate or an approximation of the value to be put on the risk occasioned by its 23 disabled insureds. Sec. 801(b) permits a life insurance reserve to be an amount "computed or estimated." Each term was purposely included and each is to be given meaning. "Estimated" permits greater flexibility in method and reasonable approximation in the result. (See Central National Life Insurance Company of Omaha v. United States, [41 AFTR 2d 78-1213], 78-1 USTC 9378, and General Life Insurance Company v. Commissioner, 137 F.2d 185 [31 AFTR 372] (C.A. 5, 1943).

6. For the year 1967 Group Life's Reserves for Fractional Premiums, Immediate Payment of Death Claims, Accidental Death Benefits, Disability-Active Lives and Disability-Disabled Lives were life insurance reserves that are includable in the numerator of the qualifying fraction because these reserves are life insurance reserves as defined in Sec. 801(b) and, thus, includable in the numerator of the qualifying fraction under Sec. 801(a)(1). They are life insurance reserves since they are amounts which were computed or estimated on the basis of recognized mortality or morbidity tables and assumed rates of interest and which are set aside to mature or liquidate future unaccrued claims arising from life insurance contracts involving life contingencies and all of these reserves were required by law.

7. The reserve for unearned premiums for accidental death benefits on life insurance contracts is an unearned premium reserve maintained on a noncancellable life, health or accident policy and is, therefore, includable in the numerator of the qualifying fraction under Sec. 801(a).

8. Accident and health premiums due and unpaid on cancellable policies are not assets within the meaning of Sec. 805(b)(4) since they do not have any offsetting component in the life insurance reserves. (See Southwestern Life Insurance Company v. United States, 560 F.2d 627 [40 AFTR 2d 77-5888] (C.A. 5, 1977).

9. Judgment shall be entered in favor [of] Group Life for a refund of the taxes and interest paid for the year 1967.

Appendix B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

No. CA3-8014-F

GROUP LIFE & HEALTH INSURANCE COMPANY

Vs.

THE UNITED STATES OF AMERICA

ORDER

This Court has previously found that Group Life & Health Insurance Company ("Group Life") is entitled to taxable status for the year 1967 as a qualified life insurance company under section 801 of the Internal Revenue Code. During the course of computations to define the amount of refund of taxes and interest due in accordance with my ruling, the parties agreed that Group Life's income tax liability as a life insurance company was $470,708.51 for the year 1967. It is similarly undisputed that Group Life actually paid income taxes for that year totaling $1,084.979.40: it paid $618,053.57 at the time of filing its 1967 income tax return on September 16, 1968, and it subsequently remitted $466,025.83 in response to the Government's issuance on July 20, 1971 of a statutory notice of deficiency. Group Life contends that the proper award to it from this lawsuit should be measured by the difference between the income taxes it paid and its corrected tax liability as a life insurance company. By this computation, Group Life would receive $614,270.89 plus a refund of interest paid of $130,533.73 and statutory interest thereon. The Government would interpose the statute of limitations

to limit any refund to $466,925.83, the amount of deficiency claimed by the statutory notice. After a complete review of the case, I conclude that Group Life's motion for judgment is meritorious and is hereby granted.

The substance of the amount in dispute relates to adjustments proposed to the 1967 taxable income of Group Life and does not rest on whether Group Life was or was not taxable as a life insurance company, the issue resolved by my earlier order in this case. Rather, these deductions were attributable to a conversion in Group Life's accounting method effected in an earlier year. The deductions were approved by the examining revenue agent, as reflected in the 30-day letter issued by the Dallas District Director on April 1, 1970, which accompanied the Revenue Agent's report.

The statutory notice of deficiency that was issued on July 20, 1971 embodied these particular agreements to permit deductions, reducing the amount of 1967 taxable income. The notice of deficiency nevertheless declared a net claimed deficiency, due to the Government's erroneous position that Group Life was not taxable as a life insurance company. The claims allowed as deductions were used to offset the increase in taxable income due to this assessment; in their absence, the deficit would have been $614,270.89.

I find that Group Life is not foreclosed from recovery of the full $614,270.89 by section 6511(a) of the Internal Revenue Code. [Group Life made timely informal claim for the adjustments unrelated to life insurance company status. The merits of these unrelated claims were considered and accepted by the IRS to fully allow their inclusion as deductions.] Consequently, the IRS cannot now raise the bar of that limitations section to argue that formal claim was not timely filed; [the Commissioner effectively waived requirement of a formal claim when he disposed of their substance on the merits to ascertain that Group Life had overpaid by an amount attributable to these unrelated deductions.]

I further find that section 6532(a)(1) does not apply to defeat refund of the allowed claim. *Bonwit Teller & Co. v. United States*, 283 U.S. 258 (1931). Rather, I find that justice is fully consonant with Group Life's recovery of $614,270.89 for a refund of income taxes paid for the year 1967, plus interest thereon as provided by law, and interest paid of $130,553.73, plus interest thereon as provided by law.

So ORDERED this 18th day of March, 1980.

United States District Judge

C-1

GROUP LIFE AND HEALTH INSURANCE COMPANY,
Plaintiff-Appellee,

v.

The UNITED STATES of America,
Defendant-Appellant.

No. 80-1561.

United States Court of Appeals,
Fifth Circuit.*
Unit A

Nov. 12, 1981.

An insurance company's challenge to a ruling by the Internal Revenue Service that company did not qualify for advantageous tax treatment of a life insurance company under the Internal Revenue Code was upheld by the United States District Court for the Northern District of Texas at Dallas, Robert W. Porter, J., and a refund was awarded. On appeal by the United States, the Court of Appeals, Randall, Circuit Judge, held that: (1) certain factual findings by the District Court were clearly erroneous; (2) insurance company failed to sustain burden of presenting substantial evidence that its reserve was computed or estimated on recognized mortality tables at assumed rate of interest; and (3) where taxpayer was not just silent concerning amount of income tax refund due it but claimed as its refund original smaller amount even after it had pur-

*Former Fifth Circuit case, Section 9(1) of Public Law 96-452 — October 14, 1980.

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portedly filed informal claim for larger amount, no claim was filed within requirements of Code.

Reversed and remanded.

1. Internal Revenue 3974

Congress, in recognition of special characteristics of life insurance risks, granted special rules of taxation to life insurance companies to reflect that greater portion of their premium income was not available for income use, and such tax advantages included deferral of taxation. 26 U.S.C.A. § 801(a, b),(b) (1) (A).

2. Internal Revenue 3980, 4616

Where Internal Revenue Service has determined that taxpayer owes deficiency, presumption of correctness places burden on taxpayer of establishing all matters necessary to show that it does not owe taxes in question, and insurance company claiming right to treatment as life insurance company accordingly bore burden of presenting substantial evidence that its reserve was computed or estimated on recognized mortality tables at assumed rate of interest. 26 U.S.C.A. § 801(a, b),(b) (1) (A).

3. Internal Revenue 3980

Insurance company in challenging Internal Revenue Service ruling that company did not qualify for advantageous tax treatment as life insurance company failed to sustain burden of presenting substantial evidence that its reserve was computed or estimated on recognized mortality tables at assumed rate of interest. 26 U.S.C.A. § 801(a, b), (b) (1) (A).

4. Internal Revenue 3980

On insurance company's challenge to Internal Revenue Service ruling that company did not qualify for advantageous tax treatment as life insurance company under Internal Revenue Code, trial court was clearly erroneous in finding that 1949 report of company contained any recom-

mendation of $750/$1,000 as basis for reserve, that company showed any relationship between $750/$1,000 and reserve based on any mortality or morbidity tables and that estimation or computation was made from 1949 report (irrespective of whether 1949 report established 75% as basis for computation of "life insurance reserve"). 26 U.S.C.A. § 801(a,b),(b)(1)(A).

5. Internal Revenue 4965

Where taxpayer was not just silent concerning amount of income tax refund due it but claimed as its refund original smaller amount even after it had purportedly filed informal claim for larger amount, no claim was filed within requirements of Code. 26 U.S.C.A. §§ 6511, 7422.

6. Internal Revenue 5003

Where income tax payer failed to file either formal or informal claim for refund of any part of taxes paid on filing of its return for 1967 within limitations period set forth in Internal Revenue Code, district court was without jurisdiction to entertain suit to extent of such recovery of such additional amounts. 26 U.S.C.A. §§ 6511, 7422.

Appeal from the United States District Court for the Northern District of Texas.

Before CHARLES CLARK and RANDALL, Circuit Judges, and SHARP,** District Judge.

RANDALL, Circuit Judge:

Defendant-Appellant, the United States of America ("United States"), brings this appeal from an adverse judgment in the court below in a suit brought against it by Group Life and Health Insurance Company ("Group Life"). Group Life, the taxpayer in this case, successfully challenged a ruling by the Internal Revenue Service ("the Service") that it did not qualify for advantageous tax treatment as a life

**District Judge of the Northern District of Indiana, sitting by designation.

insurance company under the Internal Revenue Code ("the Code") and was awarded a refund of $614,270.89 in taxes it had paid for the tax year 1967. We find that the trial court was clearly erroneous in its determination that Group Life qualified for taxation as a life insurance company and was entitled to a refund of $614,270.89, and we reverse the judgment of the court and remand the case for proceedings consistent with this opinion.

I. PROCEEDINGS BELOW

In 1967, Group Life timely filed its federal income tax return for the year 1967 and paid the amount of tax shown to be due. After examination of the tax return by agents of the Service, the Commissioner of Internal Revenue assessed a deficiency for income taxes for 1967 in the amount of $466,925.83. The basis for the finding of a deficiency was a determination that Group Life did not qualify for favorable tax treatment as a life insurance company for during 1967. Group Life paid the deficiency, filed a claim for a refund of $466,925.83 and, when the claim was denied by the Commissioner, filed suit for a refund of taxes paid. The case was tried before a judge. At the end of the hearing, the court found that the Service had erred in its determination that Group Life did not qualify as a life insurance company. The court further hled that Group Life was entitled to a refund of an amount in excess of that originally claimed in its refund suit because, according to the court, Group Life had made an "informal" claim for an additional refund based on deductions other than those it claimed as a life insurance company at the time it was being examined by the Service as to its status as a life insurance company. The United States appealed the decision of the trial court.

II. FACTUAL BACKGROUND

Group Life is a corporation organized under the Texas Insurance Code and is authorized to issue insurance policies covering life, health and accident benefits. It operates under the Blue Cross-Blue Shield trademark in Texas, and writes medical-surgical insurance, life insurance, group term life

insurance and group disability insurance to insureds in Texas. Group Life is a wholly-owned subsidiary of Group Hospital Services, Inc., a Texas non-profit corporation, and is also affiliated with Group Medical and Surgical Services, Inc., a mutual assessment company. A complete description of Group Life's organizational structure, its method of collecting premiums and its method of payments is set forth in the findings of fact made by the district court below. *Group Life and Health Insurance Company v. U. S.*, No. CA-3-8014-F, 78-2 U.S. T.C. ¶9797, 42 AFTR 2d 78-6282 (N.D. Tex.1978).

Sometime prior to 1967, Group Life, in its issuance of group term life insurance policies,[1] provided that the pre-

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[1]For purposes of our consideration of the issues, an exhaustive explanation of varying types of life insurance is not necessary. The succinct definitions given here are sufficient for our purposes.

Term insurance provides financial protection against premature death for a *specified period* only, and generally does not include cash values except for long-term policies; e.g., term to age 65. Term insurance is comparable to the usual property insurance contract in that it offers no protection or values in case of survival beyond the specified period. For instance, auto insurance offers financial protection against the covered perils for one year (in some policies six months), then expires without value. To continue protection, a new policy must be purchased or the old one renewed.

Endowment insurance, like term, protects against death for a specified period. But unlike term, insureds who survive the period are paid the policy face amount. Thus a 20-year, $20,000 endowment policy pays the beneficiary $20,000 if the insured dies within 20 years. If the insured is still alive after 20 years, the $20,000 is paid to the policyowner. Also unlike most term forms, endowment policies accumulate cash values available to policyowners upon surrender of their policies before they mature.

In contrast to endowment and term insurance, a whole life policy provides protection for the "whole of life." No time period is specified; rather, the insured's beneficiary will receive the policy proceeds regardless of the date of death if the policy is kept in force. Furthermore, whole life policies also accumulate cash values which the insured may take in lieu of maintaining the policy's death protection (i. e., upon surrendering the policy). R. Mehr, Life Insurance: Theory and Practice 60-61 (rev. ed. 1977).

mium cost of the policy would be waived for any insured individual who was disabled for more than six months as long as the person was disabled At the end of 1967, Group Life had 23 individuals who had been disabled for more than six months having total life insurance coverage of $112,000 for which premiums were being waived. Group Life established a fund (known in life insurance parlance as a "reserve"[2] and required by state insurance laws to assure solvency of the insurance company) to insure payment of the face amount of life insurance in force as to these individuals, placing $84,000 in its "disability-disabled lives" reserve. This $84,000 figure was obtained by taking 75% of the $112,000 insurance in force.

This $84,000 reserve was in addition to a number of other reserves established for different types of policies written by Group Life, including individual life insurance, health and accident policies. Group Life, in 1967, then had some reserves for life insurance policies and some for non-life, *i. e.*, accident and health, policies.

In its examination of Group Life's 1967 tax return, the Service determined that Group Life failed, under the Code, to qualify as a life insurance company because less than 50% of its total reserves were life insurance reserves.[3] The

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[2]See Section III, *infra*.

[3]The Code requires that, in order for an insurance company to be considered a life insurance company, its life insurance reserves, plus its reserves for unearned premiums and unpaid losses on noncancellable life, health and accident policies not included in the life insurance reserves must comprise more than 50% of its total reserves.

> (a) Life insurance company defined. — For purposes of this subtitle, the term "life insurance company" means an insurance company which is engaged in the business of issuing life insurance and annuity contracts (either separately or combined with health and accident insurance), or noncancellable contracts of health and accident insurance, if —
>
> (1) its life insurance reserves (as defined in subsection (b)), plus

Commissioner determined that Group Life was not a life insurance company as he computed the ratio of its life insurance reserves to total reserves to be 48.335%. The Commissioner specifically disallowed certain reserves which Group Life had included to make up the 50% necessary to qualify for taxation as a life insurance company. Included in reserves which the Commissioner disallowed were reserves for fractional premiums, immediate payment of death claims, accidental death benefits, disability-active lives and disability-disabled lives. The Commissioner also disallowed certain "unpaid losses" claims in computing the percentage of reserves for the year 1967. Because Group Life did not qualify as a life insurance company, its tax treatment changed dramatically, to the tune of an additional $466,000 owed.[4]

In Group Life's suit for a determination of whether it should be taxed as a life insurance company, the government conceded, during briefing, that the reserves for fractional premiums, for immediate payment of death claims, for accidental death benefits, and for disability-active lives were in fact life insurance reserves under § 801(b) of the Code and therefore should have been counted in determining whether or not Group Life's life insurance reserves comprised 50% of its total reserves. Not resolved before trial,

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(2) Unearned premiums, and unpaid losses (whether or not ascertained), on noncancellable life, health, or accident policies not included in life insurance reserves,

comprise more than 50 percent of its total reserves (as defined in subsection (c)).

26 U.S.C. § 801(a) (1976).

[4]For a complete discussion of the taxation of life insurance companies see Clark, The Federal Income Taxation of Financial Intermediaries, 84 Yale L.J. 1603, 1637-63 (1975); Harman, The Pattern of Life Insurance Company Taxation Under the 1959 Act, 15 Tul. Tax Institute 686 (1965). Generally, the amount of "life insurance reserve" is a factor both in determining whether a company qualifies for taxation under the Code and in the ultimate determination of the insurance company's taxable investment income and gain from operations.

however, were the questions whether reserves for disability-disabled lives and reserves for unpaid losses were properly calculated by Group Life so as to qualify it for treatment as a life insurance company.

Specifically, the Service claimed that Group Life, in calculating its "disability-disabled lives" reserve by taking 75% of the face value of the insurance in force, had not complied with the Code requirement that the reserve be "computed or estimated on the basis of recognized mortality or morbidity tables and assumed rates of interest...." 26 U.S.C. § 801(b)(1)(A) (1976). The Service asserted that the $84,000 "disability-disabled lives" reserve was not to be added to the other approved "life insurance reserves" to raise the total of life insurance reserves over 50% of the total reserves for all types of policies. Group Life maintained that it had complied with the law because its use of 75% was an estimation based on mortality or morbidity tables at an assumed rate of interest. It claimed that a 1949 report, published by the Society of Actuaries, recommended the use of 75% of the value of the insurance in force to calculate the reserve.

The trial court concluded that Group Life had estimated the reserve it established for "disability-disabled lives" correctly under the Code, that this $84,000 reserve should be added to the reserves conceded by the government to be life insurance reserves, that Group Life maintained over 50% of its toal reserves as life insurance reserves, that Group Life was a life insurance company under the Code entitled to the more favorable tax treatment and therefore was due a refund of taxes paid. The district court, having found that the "disability-disabled lives" reserve was more than adequate to reach the 50% level, declined to address whether the "unpaid loss" claim advanced by Group Life would also allow it to reach the 50% level.

Additionally, the court found that the taxpayer was entitled to recover not only the $466,000 which it paid in response to the government's claim of deficiency in 1971, and

which it had sought in its refund suit, but an additional $147,000 for a total of $614,272.85 plus interest of $130,-533.73. The increase in the figure resulted from a determination by the court that, not only was Group Life due a refund of the deficiency assessed due to the determination that it was not a life insurance company, but also it was due an additional refund for adjustments related to a conversion in its accounting method effected in an earlier year. The court found that Group Life had made a timely informal claim for the adjustments unrelated to the life insurance status. The court found that even though Group Life had never made a formal claim for these additional deductions, but a claim only for the deficiency related to its taxable status as a life insurance company, it was entitled to a refund of taxes unrelated to its "life insurance" deficiency. The court held that the Commissioner effectively waived requirement of a formal claim when he disposed of the substance of the claim on the merits in ascertaining that Group Life had overpaid its taxes by an amount attributable to the unrelated deductions during the examination of Group Life's taxable income. The court rejected the Service's claim that no formal or informal claim had been filed and that the additional refund was barred by the statute of limitations.

The government raises two issues on appeal; first, whether the "disability-disabled lives" reserve established by Group Life does, in fact, qualify as a life insurance reserve under the Code, and second, whether, if Group Life is entitled to any refund, it is entitled to the larger amount of refund awarded to it by the district court subsequent to its finding that Group Life had filed an informal claim for the full amount of the refund.

III. LIFE INSURANCE RESERVES

Consideration of the question before us, whether Group Life computed or estimated its "disability-disabled lives" reserve on the basis of recognized mortality or morbidity tables at an assumed rate of interest so as to have main-

tained a "life insurance reserve," necessitates a basic understanding of the purpose for and method of computation of life insurance reserves.[5]

Insurance companies maintain assets to pay claims which they "owe" their policy holders. Such reserves are held on accident insurance, health insurance, and life insurance. The amount of the reserve necessary to insure that a company will be able to pay its claims — as actuarily determined that these claims will arise — varies greatly depending upon the type of insurance policy.

> These reserves serve as an indicator to regulators of the company's financial soundness. Generally, the reserves must equal that amount of money which, increased at an assumed rate of interest, will yield a fund large enough to meet policy obligations at their actuarily estimated dates of maturity.

Clark, The Federal Income Taxation of Financial Intermediaries, 84 Yale L.J. 1603, 1639 (1975).

[1] Because of the nature of life insurance risks, life insurance companies must accumulate substantial reserve funds to meet future claims. Congress, in recognition of the special characteristics of life insurance risks, granted special rules of taxation to life insurance companies to reflect that a greater portion of their premium income was not available for income use. These tax advantages included a deferral of taxation. *United States v. Consumer Life Insurance Co.*, 430 U.S. 725, 753-54 & n.1, 97 S.Ct. 1440, 1455 & n.1, 52 L.Ed.2d 4 (1977) (White, Jr., dissenting).

Because life insurance companies enjoyed special tax advantages (as distinguished from casualty insurers), it be-

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[5]We do not, however, undertake to dwell at length here on the complexities of the rationale for and computation of life insurance reserves. For a complete discussion see, S. Huebner and K. Black, Jr., Life Insurance 277-290 (9th ed. 1976); D. Gregg, Life and Health Insurance Handbook 140-152 (2nd ed. 1964); R. Mehr, Life Insurance: Theory and Practice, *supra* note 1 at 634-46.

came advantageous for companies to mix life insurance business with non-life insurance business. Congress responded by deciding to tax insurance companies based on the proportion of "life insurance" business to other insurance businesses. *Id.* In order to qualify a life insurance company it was necessary for more than 50% of a company's total business to be life insurance business.

> ["If] this accident and health business was more than 50 per cent of their business, as measured by their reserves, it could not be treated as a life insurance company. On the other hand, if their accident and health insurance were incidental and represented less than 50 per cent of their business we treated them as a life insurance company." Hearings on H.R. 8245 before the Senate Committee on Finance, 67th Cong., 1st Sess., 85 (1921) (testimony of Dr. T.S. Adams, Tax Adviser to the Treasury Department).

Id.

Congress further defined what qualifies as a life insurance reserve; stating that it is an amount "computed or estimated on the basis of recognized mortality or morbidity tables and assumed rates of interest...." 26 U.S.C. § 801(b)(1)(A) (1976).

The crucial questions then for our determination here are how an insurance company establishes reserves which are "computed or estimated on the basis of recognized tables of morbidity or mortality at assumed rates of interest" to qualify as life insurance reserves and whether Group Life proved that its "disability-disabled lives" reserve was so computed or estimated

Since the question before us is the method of computation or estimation of reserves, our consideration of the issues necessitates an initial understanding of the calculation of life insurance reserves to determine if the method employed by Group Life comports with recognized methods in the life insurance industry.

An examination of the standard methods employed by life insurance companies to determine reserves shows that such reserves are based on formulas utilizing published mortality tables showing how many persons of a particular age are likely to die in any given year. The reserve is further calculated according to the age at which the policy is issued and the number of years the policy has been held. S. Huebner and K. Black, Life Insurance 280-286 (9th ed. 1976). See Appendix A, infra. Thus, the reserve for each policy varies from year to year for each policy holder and is additionally dependent upon age at issue and duration of policy.

Reserves may be determined "retrospectively" or "prospectively":

> The valuation process determines the amount of reserve necessary to meet all outstanding policy obligations. Valuation plans are said to be either (a) retrospective or (b) prospective.
>
> Determining valuation by looking backward — that is, by analyzing the actual performance of the group and determining the net premiums paid, accumulating the initial reserve, and deducting the mortality costs — is known as the "retrospective method." The retrospective method examines the income retained for the future payment of policy obligations in excess of benefits paid to date. The excess retained over benefits paid is the reserve. The "prospective method" discounts future premiums and deducts the amount so found from the present value of the benefits. It looks forward from any point of time and determines the deficiency in premium income over benefits to be collected. The difference represents the reserve. With the same mortality table and the same assumed interest rate, the reserve figure, using either the retrospective or prospective method, is identical.

J. Magee, Life Insurance 572 (3rd ed. 1959).

Furthermore, insurance companies assume that the assets which stand behind its reserves will earn interest income. The rate of interest is conservative, varying from 2½% to 3%. An additional calculation, that the assets of the insurance company will grow "at an assumed rate of interest," is thus factored into the computation or estimation of the reserve. *Huebner & Black, supra* at 286.

In summary, the reserve computation may be described as follows:

> To compute the reserve for a selected group of policies at the end of one year from their inception date, the aggregate amount of the net level premiums paid by all the members of the group is first determined. Since annual premiums are payable at the beginning of the policy year, this aggregate amount is increased for the year by the interest rate assumed for the premium calculations. The amount thus obtained is reduced by an amount represented by the tabular death claims. The remainder is the first-year reserve for the surviving policyholders. The steps may be described thus: (a) determine the net level premium for each member of the group; (b) consider the premium collected at the beginning of a policy year; (c) increase the aggregate of the premiums collected by the assumed interest rate; (d) decrease the sum thus attained by the benefits that accrue on the basis of the assumed deaths; and (e) the balance thus attained is the reserve at the end of the year under observation.

J. Magee, Life Insurance, *supra* at 568 — 69.

The general formula for the calculation of reserves using the prospective method is an equation which involves consideration of (1) the age at issue; (2) number of years

elapsed since date of issue (duration); and (3) net single premium (derived from the mortality table).[6]

As shown by the charts in Appendix A, infra, the use of the equation with appropriate figures leads to an ultimate determination of the appropriate reserve necessary to pay future claims. As demonstrated above, the use of a mortality table to determine the number of deaths per year, an assumed rate of interest to project earnings from premiums, age of the insured and duration of the insurance policy are all necessary figures to be included in any calculation of a life insurance reserve, whether it be "whole life" or "term life".[7]

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[6]The general formula for the calculation of prospective reserves is:

(Equation omitted)

V = full net level premium reserve
x = age of issue
k = number of years in premium-paying period
t = number of years elapsed since date of issue
n = number of years in policy period
A = net single premium
P = net level premium
a = present value of a life annuity due of $1

The notation "n" is used only in connection with term and endowment insurance contracts and temporary life annuities. A whole life policy is known to run to the end of the mortality table, so it is not necessary to show "n" values for it. If it is the ordinary life form, the "k" values can likewise be omitted from the formula, since it is known that the premium-paying period is coterminous with the policy period. Thus, the prospective reserve formula for an ordinary life policy can be expressed as follows:

(Equation omitted)

D. McGill, Life Insurance 231, n. 5 (rev. ed. 1967). See also, Heubner & Black, *supra* n. 5 at 632 for further explanation of the formula used.

[7]The calculations for both term and ordinary life policies both require the use of age, duration and premium. See n. 6, *supra*.

Having briefly sketched what seems to be the general practice in the calculation of life insurance reserves, it is next necessary to explain the specific type of reserve in question, "disability-disabled lives" reserves.

IV. "DISABILITY-DISABLED LIVES" RESERVE

One facet of contemporary life insurance policies which appeared in the 1930's was a "waiver of premium" provision whereby if a person became disabled (usually for a period of six months) he would not have to pay premiums but the insurance policy would continue in force to be paid upon death.

Because there was a greater risk that a disabled person would die earlier than predicted in normal mortality tables, insurance companies set up additional reserves — called "disability-disabled lives" reserves — to meet the prospect of earlier deaths among the disabled. "Waiver of premium" policies were relatively new in terms of number of persons holding such policies and the probability of deaths occurring in any one year; thus, the actuarial information to aid in developing reserves was slow to evolve. The first actuarial report to combine mortality rates, single net premiums, assumed rate of interest and duration of disability was published in 1949 by the Society of Actuaries. Committee on Group Mortality and Morbidity, 1949 Report 19-25 (1949) ("1949 Report"). See Appendix B, infra. The second, in 1968, added age at disability as a factor to be considered in determining the appropriate reserve. Committee on Group Life and Health Insurance, Group Life Insurance 188-202 (1968). See Appendix C, infra. These reports and the charts developed in them, while more simplistic than the charts available for calculation of ordinary reserves in the information presented, seem to use the same types of figures, same types of actuarial reasoning and develop reserves based on mortality tables, duration of disability (and age at disability in the 1968 report) and assumed rate of interest. Table V, 1949 Report, supra at 23, App. B.

It is clear that, after 1949, there was information available as to the figures needed for computations of disability-disabled reserves. The 1949 Report contained a chart setting forth the specific appropriate reserve amounts based on recognized mortality tables, duration of disability and assumed rates of interest. *Id.* Any taxpayer need only consult the table, determine the rate of interest to be used, find the duration of disability for the policy holder and note the appropriate reserve. *Id.*

Additionally, though there are fewer explanations in treatises of methods of calculation of the "disability-disabled lives" reserve, at least two publications indicate that this reserve is usually calculated using duration of disability and age at disability.

> The disability life reserve for the premium waiver benefit is that reserve maintained while the insured is totally disabled and is entitled to benefits. It is merely the present value of a disabled life annuity equal to the gross premium being waived. It takes the form:
>
> (Equation omitted)
>
> ...nd,... *it depends on the age at time of disability, the period since disablement, and the number of premiums that remain to be waived.*

As a practical matter, a life insurance company that writes the premium waiver benefit and any income disability benefits must consider setting up three types of disab'ed life reserves:

1. Reserves for approved claims.
2. Reserves for claims in course of settlement.
3. Reserves for claims incurred but not yet reported.

Each of these reserves represents the unaccrued liability. Any accrued liability is reported in the policy claim liability.

> *Approved claims.* As the name implies, the approved claims are all those already investigated and processed by the claims examiner. In each of these claims, the company knows the insured's age, the number of years he has been disabled, the gross premium being waived, and the remaining number of years in which premiums may be waived. In these cases, the aggregate reserve can be obtained by multiplying the yearly gross premium by the appropriate reserve factor described above [derived from premiums and years of disability].

J. Noback, Life Insurance Accounting 172 (1969) (emphasis added).

The Society of Actuaries has described the calculation of a reserve as follows:

> *Approved Premium Waivers.* Many companies include the reserve on approved premium waivers in Exhibit 11 — Claims, as in Course of Settlement — Other. Although an attained age and duration distribution of insurance on premium waiver status could be obtained and single premium reserve factors based on an appropriate disability table applied each year end, many companies obtain an average reserve factor periodically and apply against the total of such insurance at the year end. Average factors are about $750-$800 per $1,000 insurance.[8]

Education and Examination Committee of the Society of Actuaries, Part 8 Study Notes 3 (1974).

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[8]While this report stated that "many companies obtain an average reserve factor," it did not indicate whether the average is obtained from mortality or morbidity tables at an assumed rate of interest.

Group Life claims that age and duration/disability make little difference in the computation of "disability-disabled lives" reserves. Their conclusory contention, without supporting documentation is rebutted by the formula and reports presented above — all of which use at least duration of disability as a factor in computing or estimating a disability reserve.

Having determined the general actuarial information utilized to calculate "disability-disabled lives" reserves, the next question is, considering the way in which life insurance reserves generally, and "disability-disabled lives" reserves in particular, are to be calculated, according to principles set forth in life insurance treatises and publications, did Group Life compute or estimate its $84,000 reserve in an acceptable manner on the basis of recognized mortality tables at an assumed rate of interest?

V. GROUP LIFE'S METHOD

[2] It should initially be noted that, where the Service has determined that a taxpayer owes a deficiency, "[t]he presumption of correctness that follows the deficiency notice places the burden on the taxpayer of establishing all matters necessary to show that it does not owe the taxes in question." *Southwestern Life Insurance Co. v. U. S.*, 560 F.2d 627 (5th Cir. 1977), citing *Helvering v. Taylor*, 293 U.S. 507, 55 S.Ct. 287, 79 L.Ed. 623 (1935). Group Life bore the burden of presenting substantial evidence that its reserve was computed or estimated on a recognized mortality table at an assumed rate of interest. If such evidence was not presented, the trial court erred in its factual determination that Group Life's reserve was calculated correctly.

Having examined the formulation of life insurance and "disability-disabled lives" reserves generally, we must now examine the actions of Group Life to determine if those actions can be said to be a computation or estimation of reserves based on recognized mortality or morbidity tables at an assumed rate of interest.

Group Life argues that calculating its reserve by multiplying the $112,000 of insurance in force by 75% was an estimation based on the 1949 Report. Group Life asserts that the 1949 Report recommended that a reserve of $750 for every $1,000 of coverage be established and this report was the

only authority on which Group Life could rely in 1967 to calculate its reserve.[9]

[3] We find Group Life's argument flawed in three respects: (1) Group Life failed to present any evidence that its actuary, Joseph Hawkins, based the $84,000 reserve figure on any mortality or morbidity tables at an assumed rate of interest; (2) the 1949 Report does not recommend the use of only one reserve figure, but presents several figures to be used, depending on rate of interest and duration of disability; and (3) Group Life presented no credible evidence to support the proposition that the $750 was derived from any mortality or morbidity tables at an assumed rate of interest or that the figures in the 1949 Report could be computed or estimated to arrive at this $750 figure. Group Life wholly failed to sustain its burden of proof of showing that its reserve of $84,000 was computed or estimated based on recognized mortality or morbidity tables at an assumed rate of interest.

We need turn only to the testimony of Joseph Hawkins to see that his $84,000 calculation was not based on a mortality table or rate of interest. Mr. Hawkins testified that he did *not* refer to the table published in the 1949 study, that he did not refer to any other mortality table, that he used no assumed rate of interest.[10] He simply used

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[9]From our reading of life insurance treatises and publications it seems possible that disability reserves had become the subject of actuarial examination during the 1960's. Group Life presented no evidence that its actuary could not have made the appropriate calculations from available charts and formula. However, we need not decide this issue as we find that, even if Group Life is correct in that the 1949 Report was the *only* source, it failed to utilize even that source correctly.

[10]Hawkins' pertinent testimony is as follows:

Q So you looked at the policies, saw you were on the risk of $114,000, something like that, took a percent of that and set it up as a reserve?

A Yes.

Q What is the recognized morbidity table used to computate that table, Mr. Hawkins?

A Well, the basis for using that particular computation, first I point out that its longstanding and widespread use as a means of estimating the liability on group term life insurance. I don't — I can't tell you right now the name of the study or when it was published, but there are studies in the literature that tend to support the use of the 75 percent.

. . . .

Q And the 75 percent recognized percentage is not taken from any table, is it?

A It is not taken from any published table, no.

Q In other words, it's an estimate that some people think accords with what may be expected to happen?

A Yes, it is an estimate. However, it is supported by studies that actuaries have done.

Q What is the assumed rate of interest for that $84,000?

A There was not any particular rate of interest assumed during the year in which it was set up. On the other hand, there are again published studies done on various interest rates that one can refer to, three, three and a half, four percent.

. . . .

Q All right. In your testimony this morning, Mr. Hawkins, you mentioned using the 75 percent as kind of generally accepted, and there were some studies and all. Didn't you actually use the 1949 study?

A No, I didn't refer specifically to the '49 study. I used the procedure that I believed at the time to be in general use throughout the industry and approved —

Q Is there a recognized mortality table for substandard risks?

A There are substandard mortality tables that are published and accepted, yes.

Q Did you use any of them?

A I did not.

. . . .

Q Where is the seven hundred fifty dollar figure on Table V?

A It does not appear on Table V.

Q All right. Then what you are talking about, the seventy-five percent or the seven hundred fifty dollar figure, does not appear on the table, does it?

A It's not in the table.

Q All right. And that table depends upon being age forty-six or forty-seven, does it not?

A Yes, I believe that was the average age involved.

Q Okay. And the figures in Table V would vary if the age was other than forty-six or forty-seven, is that not correct?

A Yes, in all probability, they would.

Q All right. Do you know what the average ages of these twenty-two and twenty-three people were that were disabled for Group Life?

A No, sir, I do not know their ages.

Q All right. What was the assumed rate of interest used in calculating the seventy-five percent?

A The assumed rate of interest can only be arrived at by implication in that the seven hundred fifty dollars that was used contained a margin which was addressed in this report for deterioration of these kinds of risks over time.

Q Okay.

A So I can't tell you precisely what interest rate was used.

Q Well, if two and a half percent produces five hundred and fifty-seven dollars, three percent provides five hundred and thirty-two dollars, could you estimate what assumed rate of interest was being used to arrive at seven hundred fifty, half a percent?

A I can't do that, Mr. Weinberger, because the seven hundred fifty dollar figure is an average that involves loading a margin, which is not specified in this study, into these risks for assumed future deterioration.

Q All right. In other words, the seven hundred fifty dollars doesn't even depend on an assumed rate of interest, does it?

A Well, I don't think it would be accurate to state that it doesn't, but I can't tell you what rate of interest it does involve.

Q Okay. Now, when I have a life insurance reserve, Mr. Hawkins, I start out with one figure and I add something to it every year, is that not correct?

A Yes.

Q That's what's happening in Table V?

A It generally increases.

Q Go ahead and finish your answer.

A No, I was just going to say that life insurance reserves on whole life policies do increase every year.

Q Well, even in Table V, as each year in duration goes by, there is a little additional amount added to the reserve, is that not correct?

A Yes.

Q You will have to answer out loud, Mr Hawkins.

A Yes, it does increase.

Q All right. Your seven hundred fifty dollar figure on the other hand was just a constant one, isn't that correct?

A Correct.

Q You never added either the earnings from interest or additional amounts to the reserves as each year went by, is that correct?

A That's correct.

what he remembered as an industry "rule of thumb" to calculate the reserve.

Group Life argues that because Hawkins used a figure which he "remembered" to be from a report published by the Society of Actuaries, that his calculations were somehow a "computation or estimate" based on a mortality table at an assumed rate of interest. Mr. Hawkins testified that he was not sure he knew the report contained mortality tables or assumed rates of interest — his testimony that he used no tables or rates of interest indicates a severe lack of knowledge of the contents of the 1949 Report. Logically he could not have made any correct computation or estimate when he was not even sure if the 1949 Report contained the appropriate information on which to base his estimation.

Admitting, for the purposes of argument, that Mr. Hawkins did not make his computations or estimates from the report and use of a flat $750 reserve for every $1,000 of in-report and use of a flat $750 reserve for every $1,000 of in-surance ($750/$1,000) was appropriate because that was, in fact, what the report recommended. In other words, though Mr. Hawkins did not realize it, he was correctly following

the only procedure available to compute or estimate this type of reserve.[11]

Group Life repeatedly claims that the Society of Actuaries in the 1949 Report recommended the use of a ratio of $750/$1,000 to calculate a reserve and refers many times in its brief to a statement in the 1949 Report purporting to support the alleged recommendation. The Report states:

> The Waiver of Premium Disability Clause, in general, provides for waiver of premium on receipt of proof of permanent total disability in the event that disability occurs before age 60. Total disability is presumed to be permanent after it has continued for nine months and proof of continued total disability is required annually.
>
> *The total actual claims for the Waiver of Premium data have been computed by adding to the death claims 75% of the number of approved disability claims.* Although there are some indications in the study by the committee described in Section II of this report that a factor somewhat less than 75% may be more in accord with current experience, the factor in this report was maintained on a basis consistent with previous reports because of the smallness and newness of that experience.

1949 Report, supra at 1 (emphasis added).

The clear language of this statement indicates simply that a percentage of certain claims was added to other claims to attain a total number of claims in Section I of the Report. It does not in any way seem to summarize or take an average of the reserves set forth in Table V of Section II of the Report relating to "disability-disabled lives" reserves.

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[11]The United States seemed to argue at times in its brief that the 1949 Report was insufficient as being based on a recognized mortality table at an assumed rate of interest. From our research of the computation of life insurance reserves, it is quite probable that the 1949 Report met the requirement of being based on the factors required by the Code. We need not decide this issue, however, as we find that Group Life failed to "compute or estimate" its reserve on the basis of the 1949 Report.

In fact, this statement seems to be used *only* in Section I of the study. See Appendix D, infra. Group Life presented no correlation between the use of this statement in Section I of the Report with Section II of the Report (the disability-disabled lives study).

At trial, Group Life, through Mr. Hawkins, attempted to explain how the 75% figure translated into a reserve factor:

> Q Well, if you recollect Table V on Page 23 and if we assume that Group Life was setting up this reserve because these people were initially disabled in 1967, where in the world does seven hundred fifty dollars come from?
>
> A Well, the seven hundred fifty dollars comes from the fact that it was a part of my knowledge of the group insurance business at that time that all of the studies, authoritative studies, that had been done on group insurance mortality by the society committee, had adopted a practice of adding seventy-five percent of disability claims to the death claims *to construct their rates of mortality.*

IV-R. 48-49 (emphasis added).

Hawkins thus stated that the 75% "recommendation" is a factor used to *construct* mortality tables rather than being *derived* from the mortality tables (which it must be to comply with the Code). The testimony of Group Life's own actuary wholly failed to show that this 75% was an estimate based on any mortality or morbidity tables or that, when he calculated the reserve, he had any comprehension that it was so derived.

Furthermore, the explanation of Group Life's counsel at oral argument that 75% was a figure recommended by the Society of Actuaries is unsatisfactory.

> COUNSEL: The table in Table V was a pure experience formula. It did indicate a slightly less reserve

of amounts. But, the committee said we still recommend the use of the $750 reserve per $1,000 number although the experience table indicates a slightly less amount.

JUDGE: Where does it say that? That's the one problem I've had is — where in here does it say that? I must not be reading . . .

COUNSEL. Actually, its in the beginning part of the report. I believe we have it in our appendix.

. . . .

COUNSEL: C-2. Its under C-2 of our appendix in our brief where they came out and say the total actual claims were the waiver of premium data — that's the table that we are referring to — have been compiled by adding the death claim 75% of the number approved disability claims. Although there are some indications of study by the committee described in section 2 of this report that a factor somewhat less than 75% may be more in accord with current experience, the factor in this report was maintained on a basis consistent with previous reports because of the smallness and newness of the experience.

JUDGE: How does that translate into $750 per $1,000 face amount?

COUNSEL: Well, its expressed in terms of 75% of the death benefit provided and actuarial terminology is generally in terms of a $1,000 of coverage or death benefit. So, 75% of $1,000 of coverage would be $750. Now, that is $750 of a reserve for a $1,000 death benefit and it is basically considered on what they refer to as a single premium reserve amount so that *if you were selling a policy to somebody in that condition you would charge him $750 premium for it and that's the basic concept of the $750 or they referred to it as 75%.* (emphasis added)

Counsel's response that the statement in the 1949 Report is a recommendation of a $750 premium as a "net single premium" is wholly at odds with the "net single premiums" reommended in the 1949 Report. Table IV, 1949 Report, supra at 23, App. B. The net level premiums set forth in the Report necessary to provide a reserve from *$350* to *$500* — not $750.

Nor is there any further proof that this statement is any recommendation by the Society in the briefs provided to us by Group Life. Instead, the Society published a report which contained specific information in Tables IV and V and undoubtedly, if used properly, would have enabled Group Life to determine reserves which qualified as life insurance reserves.

Finally, Group Life might have been fortunate in this case if any support had been presented to the trial court that the $750/$1,000 reserve was in some way grounded on mortality at an assumed rate of interest. There was, however, no such evidence. The most that was offered by Group Life was testimony by the experts at trial that a $750/$1,000 reserve was commonly used, and by written authority supporting its common use.

> [A] death claim is considered as having been incurred at the time of disablement, and a reserve is established at that time, usually in an amount equal to approximately 75 percent of the death benefit provided.

J. Greider and W. Beadles, 1 Principles of Life Insurance, 329 (rev. ed. 1972).

While this 75% figure might have provided a shorthand method of insuring that a company maintained adequate reserves, Group Life offered no proof that such a shorthand method was derived from mortality tables using an assumed rate of interest.

Testimony at trial of Group Life's own expert, Charles Connolly, further failed to demonstrate that the purported

recommendation of $750/$1,000 as a reserve was estimated from the mortality and morbidity tables contained in the Report. To the contrary, Mr. Connolly did not look at the 1949 Report before he initially testified,[12] and could not testify that the 1949 Report contained the necessary information to make an estimation based on mortality tables or that, in fact, there was even the purported $750/$1,000 recommendation.

Mr. Connolly, after examining the 1949 Report during a recess in the trial, did testify that there was a relationship between the *number* of disability claims and the total *number* of actual claims, stating that "the number of claims has increased by 75% of the number of disability claims," but concluded only that he thought that indicated approval of a $750/$1,000 reserve. Mr. Connolly did not, in his testimony, explain how the 75% figure used to estimate total numbers of claims translated into a figure which reflected a reserve

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[12]On cross examination by the government Mr. Connolly was asked to identify the table used to make the 75% ($750/$1,000) calculation:

Q Well, what was the name of the table to utilize to make that 75 percent calculation?

A It would have been a table that was published in the 1949 committee reports of the Society of Actuaries.

Q And you say you couldn't find your copy?

A No.

Q Were you able to find a copy through contacting any of your associate actuaries?

A Well, I started hunting it Friday afternoon, and an actuary is awfully hard to find on the weekend, but I thought I could find it at home, but we moved last year, and it's stored away somewhere?

. . . .

Q Mr. Connolly, I brought an actuary along with me. Would you state for the record, for the Court, for the actuary that I brought with me, what the exact formula was that was used in this 1949 study.

A I would assume that you are referring to the 1968 study, because I couldn't find the 1949 study.

based on mortality tables at an assumed rate of interest. He failed to explain how, from the report, the figures given in the report could lead to a $750 reserve estimate. Mr. Connolly's statement that 75% of the disability claims are added to death claims to arrive at the number of actual claims does not show that a $750 reserve for $1,000 in benefits has been derived from the precise mortality and reserve tables of the 1949 Report.

Mr. Connolly's (and Group Life's) assertion that this 75% figure — which is merely a statement of how total numbers of claims are derived — is an appropriate "reserve factor" is totally inconsistent with reserve factors as calculated for disability reserves. As discussed in Part IV, *supra*, such factors seem to be derived from a relationship between gross premiums, age at disability and duration of disability. The absence of supporting testimony in the face of what seems to be contradictory information is fatal to Group Life's case.

Moreover, Table V of the 1949 Report itself does not support the $750/$1,000 as being a logical average derived from mortality tables at an assumed rate of interest. According to Group Life's own experts, most persons die within the first few years of disability. The largest disabled group from which to derive an average reserve amount would thus seem to be those disabled a shorter period of time. The reserves recommended in the earlier years of disability in Table V of the 1949 Report at both the 2½% and 3% assume interest are *significantly* lower than $750. It seems inconceivable that any true estimation of an average reserve would be $750 when most of the disabled are not disabled long enough to reach the $750 reserve, which according to Table V, is needed only after nine years of disability. To the contrary, Group Life's method, whereby Mr. Hawkins used a "rule of thumb" which he claimed existed in the industry, stands in marked distinction to the sophisticated mathematical calculations utilized to arrive at reserves in the insurance industry generally and in contrast to *at least* one published method of computation of "disabled life" reserves.

Finally, testimony of Werner Marwitz, an expert witness called by the Service, contradicts that of Group Life and is much more consistent with what seem to be the principles of computation or estimation of reserves. Mr. Marwitz testified that, actuarily speaking, use of an average of $750 to calculate a reserve would not be in compliance with the requirements of the Internal Revenue Service.[13] Marwitz stated that averages, while perhaps adequate for determination of reserves for "credit life"[14] insurance, were not necessarily adequate for reserves for "disability-disabled lives" reserves.

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[13]Mr. Marwitz testified:

Q Mr. Marwitz, one of the items concerns whether the seven hundred fifty dollar figure used by Group Life in calculating its disability-disabled lives reserves was calculated on, estimated or calculated on, a recognized table of mortality or morbidity rates. Do you have an opinion as to whether that was so estimated or calculated?

A Yes, I do.

Q What is your opinion?

A My opinion would be that the seven hundred fifty dollars does constitute a solvency reserve to satisfy the liability requirements of the company in the annual statement and to satisfy the requirement of the State Insurance Department. It is, however, not a life insurance reserve within the meaning of Section 801(b) of the Internal Revenue Code of 1954.

Q And why is that?

A Because it is not based or computed or estimated on the basis of mortality or morbidity tables and assumed rates of interest.

Q All right. Have you ever run across in your practice prior to coming with the Internal Revenue Service the seven hundred fifty dollar rule of thumb?

A Oh, yes. We used the same figures at Mutual Service for many years, and if my recollection is correct we changed it around 1964, '65, '66, around that period, because the seven hundred fifty dollars would not comply with the requirements of the Internal Revenue Service.

[14]Credit life insurance is insurance issued to a person who owes a sum of money to insure that if the borrower dies, the money will be paid to the lender.

Furthermore, Marwitz testified that the duration of disability is a factor in the computation of a "disability-disabled lives" reserve.[15]

Thus, the testimony of Group Life's own actuary and two independent actuaries shows:

(1) Group Life, in 1967, made no attempt to use the 1949 Report to compute or estimate the reserve needed;

(2) The 1949 Report does not recommend use of a $750/$1,000 reserve;

(3) Group Life further wholly failed to show that the $750/$1,000 reserve was an estimate derived from any existing mortality tables and that it was predicated on any assumed rate of interest.

Case law and Service Revenue Rulings also fail to support Group Life's position that its calculation was any form of an acceptable computation or estimation. While it is undisputed that a "disability-disabled lives" reserve may be a life insurance reserve, *Commissioner v. Monarch Life Insurance Company*, 114 F.2d 314 (1st Cir. 1940); Rev.Rul. 70-190, 197 — 1 C.B. 150, this is dependent upon the reserve having been estimated or computed on the basis of recognized mortality or morbidity tables, at assumed rates of interest. Cf. Rev.Rul. 70-190, *supra* at 150. None of the authority cited by Group Life supports the proposition that its method of calculation is within the parameters of the Code. For example, *General Life Insurance Co. v. Commissioner*, 137 F.2d 185 (5th Cir. 1943), cited by Group Life, was decided on the basis of the Code in effect before the 1942 Code revision which required that calculation of life insurance reserves be made on the basis of mortality and morbidity tables. In *General Life*, the question was whether a fund computed by applying a percentage of 60% to the assessments of policy holders was a life insurance reserve. The court held that a reserve need not be actuarily calcu-

[15] Q Could you use an average duration?

A Well, I don't really think so.

lated under the 1936 Code. That 1936 Code, however, was amended in 1942 to include today's present requirements of computation of estimation based on mortality tables at an assumed rate of interest. That case is no longer authority for Group Life's position.

Furthermore, the case presented to the United States Court of Claims in *Central National Life Insurance of Omaha v. U.S.*, 574 F.2d 1067 (Ct.Cl.1978), and relied upon by Group Life is materially different from the one here. In *Central National* the question was whether a reserve calculated by applying a percentage of gross unearned premiums qualified as a life insurance reserve. At trial the taxpayer proved that a percentage based on premiums which were based on mortality tables were used to calculate the reserves, and that there was no better information available. *Id.* at 1080.

Here, there was no showing that a percentage based on premiums based on mortality tables was used. Additionally, the 1949 Report contained different reserve requirements for different durations of disability; the "better information" similar to that which the taxpayer proved he lacked in *Central National*. Group Life's failure to use a percentage based on a mortality table renders its reliance on *Central National* inappropriate.

Finally, the taxpayer in *Central Life* submitted evidence proving that a computation derived directly from a mortality or morbidity table was close to that derived from the shorthand method. There was no showing at trial by Group Life as to what its reserve would have been if it had used the proper tables in the 1949 Report.

[4] In reversing the trial court, we are mindful that we may do so only if its findings of fact were clearly erroneous. The record, as explained above, reflects that there was no evidence to support the finding that the computation or estimation by Group Life was based on mortality tables at an assumed rate of interest. The trial court erroneously, without proof by Group Life, accepted the fact that the "75%"

statement in the 1949 Report alluded to a factor based on mortality tables, without requiring that Group Life bear its burden to demonstrate any coherent facts to support its position that the $750/$1,000 reserve was a *result* of an average taken from the mortality rates and interest rates in the 1949 Report.

The trial court's further conclusion that Group Life's estimation was based on a presumed rate of interest is also clearly erroneous. The trial court stated:

> The 1949 Report, which formed the basis of the $750 factor, takes into account the probability of recovery, the probability of death, *and an assumed interest rate of 3%.*

II-R. 291 (emphasis added). However, Mr. Hawkins at trial stated that the $750/$1,000 reserve factor apparently combined both interest rates shown in Table V. In fact, there is nothing in the 1949 Report or in testimony to show that any average reserve was calculated on any rate of interest.

Finally, the trial court, in finding that there had been an appropriate "reserve factor" established, erroneously relied on the testimony of Mr. Hawkins to show that a reserve factor had been calculated by use of average ages and duration. (II-R. 292) In fact, Mr. Hawkins did not state that age and duration had definitely been used (as is the case in the computation or estimation of most reserves) but only *assumed* such calculations had been used. He stated:

> I am certain that an average age was computed and an average age of the duration of the disability itself would have had to be made to determine the proper reserve to establish the reserve factor. It varies a great deal according to how long an individual has been disabled, so an assessment was made of the ages at which these individuals became disabled and the duration of their disability to arrive at a reserve factor that would be appropriate to use to measure the overall risk.

He could, of course, do no more, as he had not even inspected the Report prior to his use of $750/$1,000 to calculate the reserve.

Thus the trial court was clearly erroneous in its findings:

(1) That the 1949 Report contained any recommendation of $750/$1,000 as a basic for a rserve;

(2) That Group Life showed any relationship between $750/$1,000 and a reserve which is based on any mortality or morbidity tables; and

(3) That the estimation or computation was made from the 1949 Report (irrespective of whether the 1949 Report established 75% as a basis for a computation of "life insurance reserve").

Group Life's use of the 75% figure to calculate its reserve, in such stratling contrast to the methodology described in life insurance treatises, without any proof by Group Life that its method was acceptable, cannot stand.

We hold therefore that Group Life failed to sustain its burden of showing that its computation or estimation was based on recognized mortality tables at an assumed rate of interest and that the judgment of the district court must be reversed and the case remanded for consideration of Group Life's undecided alternative claims.[16]

VI. INFORMAL CLAIM FOR REFUND

[5] As a rseult of his determination that Group Life did not qualify for life insurance company status pursuant to

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[16]Group Life claims we could refigure its reserve based on Table V to find that a reserve calculated by use of that table would cause it to reach the 50% level. However, in order for us to recompute, the original figure must have been an estimate, calculated in advance, based on mortality tables and rates of interest. Since we find Group Life's calculation to be deficient in this respect, recomputation is not appropriate. *Cf. Pacific Mutual Life Insurance Co. v. Commissioner*, 48 T.C. 118 (1967), rev'd on other grounds, 413 F.2d 55 (9th Cir. 1969).

Section 801 of the Code, the Commissioner determined a deficiency in the amount of $466,925.38. Group Life paid the deficiency and then filed a claim for refund, asserting that its correct liability was the amount stated on its return. When Group Life filed its complaint in the district court it sought a refund of $466,925.38. After the district court's opinion was filed, Group Life moved for judgment in the amount of $614,270.89, asserting that it had overpaid its taxes in the additional amount of $147,345.06. The district court granted Group Life's motion. The district court held that the taxpayer had filed an informal claim of refund for the actual taxes and that *Bonwit Teller & Co. v. United States*, 283 U.S. 258, 51 S.Ct. 395, 75 L.Ed. 1018 (1931), mandated a refund to the taxpayer.

The United States claims that Group Life cannot garner this additional refund because it did not follow the requirements necessary to bring suit, in that it did not file a refund claim for the additional amount with the Commissioner of the Internal Revenue within three years of September 12, 1968, the date the 1967 return was filed according to the statutory requirements.[17] The Uinted States asserts that the

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[17]The pertinent statutes are:

(a) [as amended by sec. 82(a), Technical Amendments Act of 1958, P.L. 85-866, 72 Stat. 1606] Period of Limitation on Filing Claim. — Claim for credit or refund of an overpayment of any tax imposed by this title in respect of which the taxpayer is required to file a return shall be filed by the taxpayer within 3 years from the time the return was filed or 2 years from the time the tax was paid, whichever of such period expires the later, or if no return was filed by the taxpayer, within 2 years from the time the tax was paid. Claim for credit or refund of an overpayment of any tax imposed by this title which is required to be paid by means of a stamp shall be filed by the taxpayer within 3 years from the time the tax was paid.

26 U.S.C. § 6511 (1976).

(a) *No Suit Prior to Filing Claim for Refund.* — No suit or proceeding shall be maintained in any court for the recovery of any internal revenue tax alleged to have been erroneously or illegally assessed or collected, or of any penalty claimed to have

refund claim for the additional amount should have been made by September 16, 1971, and that no formal or informal claim was made in that time.

The District Court stated (II-R. 553) that Group Life made a timely "informal claim" for refund with respect to the additional taxes. However, it appears from the record that no informal or formal claim for the refund of the additional amounts at issue was ever made by Group Life to the Commissioner. The record indicates only that, in determining the amount of the deficiency asserted against Group Life, certain additional deductions were allowed by the examining agent, thereby reducing the amount of additional taxes owing under the determination that Group Life failed to qualify for taxation as life insurance company. There is no indication from the record that Group Life had previously sought a refund — either formally or informally — of the taxes with its return on the basis of such additional deductions. Moreover, in the claim for refund it did ultimately file, Group Life sought to recover only the additional amount it paid in satisfaction of the deficiency asserted by the Commissioner. Not only did that claim make no mention of the additional amount or the grounds on which its present claim for that additional amount is based, but it also specifically indicated that the correct amount of its tax liability was the same amount ($618,053.57) as stated on its return. II-R. 515. Additionally, its complaint before the District Court requested refund of the original deficiency.

This case is closely analogous to one previously examined by this court. *Southwestern Life Insurance Company v. U.S.*, 560 F.2d 627 (5th Cir. 1977). In that case, the taxpayer

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been collected without authority, or of any sum alleged to have been excessive or in any manner wrongfully collected, until a claim for refund or credit has been duly filed with the Secretary or his delegate according to the provisions of law in that regard, and the regulations of the Secretary or his delegate established in pursuance thereof.

26 U.S.C. § 7422 (1976).

alleged that an informal claim had been filed. The court rejected the argument, similar to the one made here, stating:

> Nothing stated by defendants indicates that the taxpayer met the requirements of the statute, as interpreted by the courts, that a written claim calling specific attention to the alleged error and the basis on which the claim was being made was ever communicated to the Commissioner.

Id. at p. 632. Here, where Group Life was not just silent concerning the amount of refund due it, but claimed as its refund the original smaller amount even after it had purportedly filed an informal claim for a larger amount, we find that no claim was filed within the requirements of the Code.

Bonwit Teller, supra, upon which the District Court relied as authority for allowing the refund here, provides no support for Group Life's position. In *Bonwit Teller*, the Commissioner determined that the taxpayer had overpaid its tax for the year 1919, and specifically indicated to taxpayer that the refund would be made if taxpayer signed a waiver that was statutority required. The taxpayer executed the waiver, but after expiration of the period of limitations on claims for refund, the Commissioner refused to refund the overpayment on the ground that no timely formal claim for refund was filed. The waiver and letter transmitting it, however, was considered and treated by the Commissioner as constituting a claim for refund, and the Commissioner allowed the claim and scheduled a certificate of overassessment. The Supreme Court found that this constituted a sufficient claim under the statute, and held that the Commissioner could not deny refund on the ground that no formal claim was filed. The Court stated that the suit was not based on payment of the tax in 1919, but was grounded upon the Commissioner's certificate, issued in 1927, showing taxpayer entitled to a refund of the amount stated. The cause of action upon which the suit was grounded was determined by the Court to have arisen upon de-

livery of the certificate to taxpayer. *Id.* 283 U.S. at 265, 51 S.Ct. at 398.

The case before us is markedly different. Here, no action on the part of the Commissioner indicates that he considered and treated Group Life's course of conduct prior to the deficiency determination as an informal claim for refund. Nor did the Commissioner schedule a certificate of overassessment that would constitute allowance of that claim, or otherwise determine that Group Life had overpaid its taxes for the year 1967.

[6] Group Life failed to file either a formal or informal claim for refund of any part of the taxes paid on the filing of its return for 1967 within the limitations period set forth in the Code. The District Court was without jurisdiction to entertain the suit to the extent it sought recovery of those additional amounts. Accordingly, the court erred in granting Group Life's motion for judgment in an amount in excess of the amount claimed by taxpayer in its claim for refund, *i.e.*, $466,925.38.

The judgment of the district court is reversed and the case is remanded for further proceedings consistent with this opinion.

REVERSED and REMANDED.

APPENDIX A

TABLE 24-3. Cost of insurance for $1,000 ordinary life policy, age 35, *1958 CSO Table* and 2½ percent interest, net level premium reserves

(1) Policy Year [t]	(2) Attained Age at Beginning of Policy Year [=35+ (t—1)]	(3) 1958 CSO Mortality Rate [=q35+ (t—1)]	(4) Amount at Risk During Year [=1,000 (1—1V35)]	(5) Cost of Insurance [=(3)X (4)]
1	35	.00251	$984.36	$ 2.47
2	36	.00264	968.41	2.56
3	37	.00280	942.17	2.67
4	38	.00301	935.68	2.82
5	39	.00325	918.95	2.99
6	40	.00353	901.99	3.18
7	41	.00384	884.83	3.40
8	42	.00417	867.45	3.62
9	43	.00453	849.88	3.85
10	44	.00492	832.10	4.09
11	45	.00535	814.15	4.36
12	46	.00583	796.03	4.64
13	47	.00636	777.76	4.95
14	48	.00695	759.37	5.28
15	49	.00760	740.88	5.63
16	50	.00832	722.29	6.01
17	51	.00911	703.65	6.41
18	52	.00996	684.95	6.82
19	53	.01089	666.21	7.26
20	54	.01190	647.46	7.70
21	55	.01300	628.71	8.17
22	56	.01421	609.98	8.67
23	57	.01554	591.31	9.19
24	58	.01700	572.71	9.74
25	59	.01859	554.22	10.30
26	60	.02034	535.86	10.90
27	61	.02224	517.66	11.51
28	62	.02431	499.63	12.15
29	63	.02657	481.81	12.80
30	64	.02904	464.23	13.48
31	65	.03175	446.91	14.19
32	66	.03474	429.90	14.93
33	67	.03804	413.26	15.72
34	68	.04168	397.03	16.55
35	69	.04561	381.23	17.39
36	70	.04979	365.96	18.21
37	71	.05415	350.90	19.00
38	72	.05865	336.28	19.72
39	73	.06326	321.94	20.37
40	74	.06812	307.84	20.97
41	75	.07337	294.00	21.37
42	76	.07918	280.44	22.21
43	77	.08570	267.24	22.90

S. Huebner and K. Black, *supra* at 282.

TABLE 24-6. Terminal reserve per $1,000 — *1958 CSO Table*, varying rates of interest (Ordinary life, male age 35)

Duration	2½ Percent	3 Percent	3½ Percent
1	$ 15.84	$ 14.30	$ 13.08
10	167.90	156.29	145.49
20	352.54	334.23	316.81
30	535.77	516.21	497.20
50	811.36	799.12	786.82
60	905.46	898.40	891.21

S. Huebner & K. Black, *supra* at 287.

APPENDIX B

GROUP LIFE WAIVER OF PREMIUM EXPERIENCE

TABLE IV

Mortality Assumption After Ten Years	Interest Rate	Net Single Premium		Total
		First Ten Years	Succeeding Years	
Experience by Lives, all Ages and both Sexes Combined Average Age at Approval of Disability Claim 46				
Hunter's	2½%	$352.30	$195.71	$548.01
	3	316.81	177.12	523.93
A M (5)	2½	352.30	173.04	525.34
	3	346.81	153.00	400.81
C S O	2½	352.30	172.41	524.71
	3	346.81	152.36	499.17
Experience by Amounts, all Ages and both Sexes Combined Average Age at Approval of Disability Claim 47				
Hunter's	2½%	$346.46	$210.99	$557.45
	3	341.04	191.21	532.25
A M (5)	2½	346.46	187.98	534.44
	3	341.04	166.68	507.72
C S O	2½	346.46	187.24	533.70
	3	341.04	165.92	506.96

TABLE V

Disability Claim Reserves per $1,000 of Insurance Assuming Hunter's Ultimate Mortality Rates after 10 Years

Duration	Experience by Amounts		Experience by Lives	
	2½%	3%	2½%	3%
0	$557	$532	$548	$524
1	567	537	555	527
2	594	560	579	547
3	624	588	608	574
4	654	616	638	601
5	650	641	666	625
6	703	664	691	652
7	724	685	713	675
8	740	702	732	694
9	752	715	745	707
10	760	723	754	716

1949 Report, *supra* at 23.

APPENDIX C
TABLE 7A

Disabled Life Reserves per $1,000 of Insurance* at 3 Per Cent

Based on Graduation by Lives for Both Sexes Combined

Duration from Disablement	AGE AT DISABLEMENT									
	19 and Under	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60 and Up
At disablement	$102	$166	$246	$322	$389	$466	$553	$628	$697	$720
3 quarters	105	169	251	329	398	477	566	642	713	736
1 Year	105	166	242	317	384	465	557	636	710	735
5 quarters	107	166	239	313	380	461	555	634	709	735
6 quarters	111	172	242	315	382	463	557	635	709	736
7 quarters	117	180	250	323	389	470	562	639	711	738
2 years	125	190	259	330	399	478	568	643	718	749
3	168	229	297	370	433	506	589	657	722	748
4	215	274	339	405	467	531	606	668	731	758
5	258	312	371	430	489	547	618	677	738	768
6	289	337	391	449	506	562	629	685	744	777
7	312	356	408	466	521	576	640	694	751	786
8	328	371	428	482	536	591	651	705	759	796
9	342	384	437	497	550	606	663	716	766	802

DURATION 10 AND BEYOND

Attained Age	Reserve	Attained Age	Reserve	Attained Age	Reserve
27	$353	52	$618	76	$837
28	360	53	630	77	844
29	368	54	642	78	850
30	377	55	653	79	856
31	386	56	664	80	861
32	396	57	675	81	867
33	405	58	685	82	873
34	416	59	696	83	878
35	426	60	707	84	883
36	438	61	717	85	888
37	450	62	728	86	894
38	462	63	738	87	898
39	475	64	748	88	902
40	487	65	758	89	907
41	498	66	768	90	912
42	509	67	774	91	917
43	521	68	782	92	922
44	532	69	789	93	927
45	542	70	796	94	933
46	553	71	803	95	939
47	563	72	810	96	946
48	574	73	816	97	954
49	585	74	823	98	963
50	596	75	830	99	971
51	607				

1968 Report, *supra* at 199.

APPENDIX D

TABLE II

Experience on 1946-1948 Combined

Type 0 — Cases with 50 or more lives and cases with fewer than 50 lives which had 50 lives or more at issue

Industry Code No.	Industry	Waiver of Premium					Extended Death Benefit				Total & Permanent Disability				
		Years Exposed	Total[a] Actual Claims	Ratio A/E	No. of Claims Accid.	Dis.	Years Exposed	Total Actual Claims	Ratio A/E	No. of Cl. Accid. Death	Years Exposed	Total Actual Claims	Ratio A/E	No. of Claims Accid.	Dis.
	Agriculture														
1	Florists and Nurserymen	7750	71.50	55.5	4	2	3850	27	55.7	5	4019	36	46.0	2	4
2	Fruit Growing	1122	5.00	41.3	2		7938	53	57.2	4	687	6	—	1	1
3	Stock Ranging and Ranching	511	2.00	—	1		61		—		975	7	—		2
4	General Farming and all other Agriculture	11536	80.50	61.4	11	2	1620	11	52.4	1	2383	20	73.6	1	2
Total		20752	168.00	61.2	18	4	13478	91	55.8	10	1991	78	55.2	4	9
	Mining														
10	Coal-Bituminous (Surface Mining)	3965	30.00	65.9	10		1091	9	67.7	1	974	9	—		3
11	Coal-Bituminous (Underground Mining)	15303	179.75	90.8	32	17	51001	432	71.2	81	8701	130	90.5	25	21
12	Coal-Authracite	9706	119.50	92.9	16	18	8087	98	87.4	14	1089	10	60.6		3
13	Iron (Surface Mining Only)	219	1.00	—	1		1258	11	74.8	5	18011	235	82.2	20	21
14	Iron (Underground Mining)	1711	15.25	87.6	4	3	14373	113	72.6	20	513	6	—	1	
15	Copper (Surface Mining Only)	21001	220.00	83.1	31	28	62070	317	81.6	60	14613	218	91.2	11	21
16	Copper (Underground Mining)	1153	13.25	93.3	3	3	8510	70	86.0	21	5170	52	87.1	6	12
17	Lead & Zinc Mines (Surface Mining Only)	188	1.00	—			3280	36	79.5	6					
18	Lead & Zinc Mines (Underground Mining)	603	9.75	—	5	1	10123	81	65.3	12	1481	28	110.7	7	4
19	Other Metal Mines (Surface Mining Only)	206	1.00	—	1		323	3	—		3997	36	89.3	3	

APPENDIX D

TABLE II — (Continued)
Experience on 1946-1948 Combined
Type 0 — Cases with 50 or more lives and cases with fewer than 50 lives which had 50 lives or more at issue

Industry Code No.	Industry	Wavier of Premium					Extended Death Benefit				Total & Permanent Disability				
		Years Exposed	Total* Actual Claims	Ratio A/E	Claims No. Accid.	Claims of Dis.	Years Exposed	Total Actual Claims	Ratio A/E	No. of Cl. Accid. Death	Years Exposed	Total Actual Claims	Ratio A/E	No. of Accid.	Claims Dis.
20	Other Metal Mines (Incl. Surface & Underground)	6708	69.50	87.6	10	18	6599	33	51.6	11	4572	50	109.9	4	10
21	Salt Production	1114	12.00	80.0	1		1031	11	91.7	2	0875	102	00.2	5	9
22	Minerals (Clay, Shale, Talc, Phosphate, Feldspar, etc.)	2259	21.25	96.2	1	3	1617	20	98.5	2	17517	193	96.4	28	23
23	Quarries (Slates, Stone and Marble)	4163	33.50	69.4	5	2	7801	90	87.0	10	12192	157	91.5	21	18
Total		69018	729.75	85.1	126	93	179063	1881	77.5	257	96170	1226	90.0	131	147
	Oil														
30	Mineral Oil Prod., Refining & Distribution	170142	1258.50	61.2	121	74	422336	2574	60.6	327	287435	2501	74.4	199	480
	Construction														
40	Construction (Steel — Incl. Steel Bridges)	2598	26.00	97.4	4		3252	25	69.8	2	13286	114	61.3	9	17
41	Construction (Wood, Brick and Stone)	16113	103.75	61.4	12	5	5100	47	71.1	16	4357	44	68.5	2	1
42	Shipbuilding (Iron and Steel)	36960	375.50	80.1	21	54	19203	185	76.7	12	6718	61	70.0	4	7
43	Shipbuilding (Wood)	1752	10.00	17.6	2		892	7	—		111	9	—		3
44	Road Construction (Incl. Sewers, Bridges, etc.)	7219	61.50	61.1	6	6	14769	153	88.9	17	4212	67	89.5	3	6
Total		61912	576.75	74.6	45	65	43216	417	78.8	47	28991	298	73.7	18	31

*Number of Death Claims plus three-fourths of number of Disability Claims.

1949 Report, *supra* at 4-5.

Adm. Office, U.S. Courts — West Publishing Company, Saint Paul, Minn.

Appendix D

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT*

UNIT A

No. 80-1561

GROUP LIFE AND HEALTH INSURANCE COMPANY,
Plaintiff-Appellee,

versus

UNITED STATES OF AMERICA,
Defendant-Appellant.

Appeal from the United States District Court
for the Northern District of Texas

ON PETITION FOR REHEARING AND
SUGGESTION FOR REHEARING EN BANC

(Opinion November 12, 1981, 5 Cir., 198 , F.2d).

(January 6, 1982)

Before CHARLES CLARK and RANDALL, Circuit Judges, and SHARP**, District Judge.

PER CURIAM:

(X) The Petition for Rehearing is DENIED and no member of this panel nor Judge of this Administrative Unit in regular active service having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Local Fifth Circuit Rule 16; Fifth Circuit Judicial Council Resolution of January 14, 1981), the suggestion for Rehearing En Banc is DENIED.

( ) The Petition for Rehearing is DENIED and the judges in regular active service of this Administrative Unit

having been polled at the request of one of said judges and a majority of said judges not having voted in favor of it (Rule 35, Federal Rules of Appellate Procedure; Local Fifth Circuit Rule 16; Fifth Circuit Judicial Council Resolution of January 14, 1981), the suggestion for Rehearing En Banc is also DENIED.

( ) A member of this Administrative Unit in active service having requested a poll on the reconsideration in this cause en banc, and a majority of the judges in active service of said unit not having voted in favor of it, rehearing en banc is DENIED.

ENTERED FOR THE COURT:

Carolyn Denice Randall
United States Circuit Judge

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* Former Fifth Circuit case, Section 9(1) of Public Law 96-452 — October 14, 1980.

** District Judge of the Northern District of Indiana, sitting by designation.

E-1

APPENDIX E

1949 REPORT
OF THE
COMMITTEE ON GROUP
MORTALITY AND MORBIDITY

SOCIETY OF ACTUARIES
208 South La Salle Street, Chicago 4, Illinois

1949 REPORT OF THE COMMITTEE ON GROUP MORTALITY AND MORBIDITY

SECTION I — GROUP LIFE INSURANCE

This report adds the experience of the calendar year 1948 under group life insurance policies to that previously reported in T.A.S.A. XLIX 477 and covers the period 1946-1948. The experience is analyzed by type of policy, disability provision and industry. The analysis by type of policy separates the experience as follows:

Type 0 — Cases with 50 or more lives and cases with fewer than 50 lives which had 50 lives or more at issue.

Type 3 — Cases with fewer than 50 lives at issue, which remain in that class.

Trusteeship and Association cases insuring employees of member employers of the trusteeship or association and union cases where insurance depends on continued employment are excluded. The attempt made in the previous report to investigate experience of certain categories of such cases has been discontinued for the time being because of the difficulty in making a satisfactory classification of such cases.

The experience under each of the three common disability provisions is shown separately. Following is a description of these provisions:

(i) The Waiver of Premium Disability Clause, in general, provides for waiver of premium on receipt of proof of permanent total disability in the event that disability occurs before age 60. Total disability is presumed to be permanent after it has continued for nine months and proof of continued total disability is required annually.

The total actual claims for the Waiver of Premium data have been computed by adding to the death claims 75% of the number of approved disability

claims. Although there are some indications in the study by the committee described in Section II of this report that a factor somewhat less than 75% may be more in accord with current experience, the factor in this report was maintained on a basis consistent with previous reports because of the smallness and newness of that experience.

(Petitioner's Note to this Appendix: The entire 1949 Report of the Committee consists of 52 printed pages and discusses two other unrelated group problems and these pages have been omitted from this App. E.)

SECTION II — DISABILITY CLAIMS UNDER THE GROUP LIFE WAIVER OF PREMIUM CLAUSE

A. Introduction

Early in 1938, most companies writing group life insurance adopted a disability clause for new policies which provided for the waiver of premiums during disability on receipt of proof of permanent total disability occurring before age 60. Under this provision, total disability is presumed to be permanent after it has continued for nine months, but proof of continued total disability is required annually. This report presents a study of disability claims approved under the Waiver of Premium Disability Clause through December 31, 1948. The total experience involves 5,461 claims representing a total of $10,085,761 of insurance.

In evaluating the significance of the material brought out in this study a number of factors should be kept in mind. For one thing, this disability clause has been in effect for a relatively short time and volume of insurance has been growing rapidly. Consequently, the experience to date under approved claims does not represent the level that may ultimately be attained.

Widely differing employer practices exist with regard to continuing or terminating premium payments on disabled employees. The full effect of these has undoubtedly not been felt nor has the impact of changing economic factors on such practices been experienced. Then too, the rate of recovery from disability is greatly affected by economic considerations. The period covered by this study, although dislocated by the war, was one of relative prosperity.

B. Form of the Contribution

The contributing companies prepared an individual punched card for each life becoming disabled prior to January 1, 1949. Data was included for amount of insurance; date of approval; mode of termination of disability, if terminated; date of termination; age nearest birthday at date of approval; and sex (except for a large contributor whose cards were not coded for sex). The study was contributed to by the Aetna Life Insurance Company, Connecticut General Life Insurance Company, Equitable Life Assurance Society, John Hancock Mutual Life Insurance Company, Metropolitan Life Insurance Company, Prudential Insurance Company of America, Sun Life Assurance Company of Canada and The Travelers Insurance Company.

Table I exhibits the total experience by age at disability for both lives and amounts. Because of the small amount of data as yet available, it was decided to complete the study by combining all ages at disability.

C. Analysis by Lives and Amounts

Using the data for both sexes and all ages combined, the exposed to risk of death and exposed to risk of recovery were computed for each year of disability, beginning with the time of disability claim approval. Crude death and recovery rates were then computed for each of the first 10 years of disability. (There was no exposure after 10 years of disability.)

TABLE I

Total Experience Contributed to the Study

Age at Approval	Existing	Recoveries	Deaths	Total
		Lives		
10-19	7	2	1	10
20-29	304	220	76	600
30-39	510	230	137	877
40-49	847	208	267	1,322
50-59	1,507	214	541	2,262
60 and up	267	26	97	390
Total	3,442	900	1,119	5,461
		Amounts		
10-19	$ 6,000	$ 2,000	$ 1,000	$ 9,000
20-29	497,050	340,609	107,250	944,909
30-39	930,680	418,906	228,650	1,578,236
40-49	1,616,401	361,200	492,683	2,470,284
50-59	2,907,898	405,690	992,658	4,306,246
60 and up	569,136	43,110	164,840	777,086
Total	$6,527,165	$1,571,515	$1,987,081	$10,085,761

The crude rates of recovery were graduated by a Whittaker-Henderson type A formula, with a = 1. Enough zeroes were added to the series of observed rates of recovery to force the graduated rates to taper off to zero in the 11th year of disability.

The graduation of the crude death rates was also done by a Whittaker-Henderson type A formula with a = 1, extending the death rates by means of Hunter's ultimate rates of mortality appearing in T.A.S.A. XII, page 51, "Reserves and Net Premiums for 'Waiver of Premium' on Permanent Disability". The average age at approval of disability claim in the experience was found to be 46 by lives

TABLE II

Experience by Lives

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
							Crude		Graduated	
Year of Disability	In force Beginning of Year In	Recoveries Wn	Deaths On	Existing en	Exposed to Recovery In − ½(On + en)	Exposed to Death In − ½(Wn + en)	Recovery Rate (3) ÷ (6)	Death Rate (4) ÷ (7)	Recovery Rate	Death Rate
1	5,461	413	686	1,121	4,577	4,694	.09063	.14614	.09822	.13534
2	3,241	280	229	711	2,771	2,745	.10105	.08342	.08836	.09638
3	2,021	124	102	618	1,661	1,650	.07465	.06182	.07136	.07167
4	1,177	50	54	409	945	947	.05291	.05702	.05471	.05503
5	664	17	21	234	536	538	.03172	.03903	.04066	.04513
6	392	8	14	132	319	322	.02508	.04348	.03083	.04127
3	238	6	10	108	179	181	.03352	.05525	.02388	.04072
8	114	2	1	69	79	78	.02532	.01282	.01655	.04150
9	42	0	2	30	26	27	0	.07407	.00868	.04649
10	10	0	0	9	5	5	0	0	.00305	.04898
11	1	0	0	1	0	0	0	0	0	0
Total	13,361	900	1,119	3,442	11,078	11,187				

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TABLE III

Experience by Amounts

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
							Crude		Graduated	
Year of Disability	In Force Beginning of Year	Recoveries Wn	Deaths On	Existing en	Exposed to Recovery In − ½ (On + en)	Exposed to Death In − ½ (Wn + en)	Recovery Rate (3) ÷ (6)	Death Rate (4) ÷ (7)	Recovery Rate	Death Rate
1	10,085,761	742,135	1,267,083	2,302,201	8,301,119	8,563,593	.08940	.14796	.09886	.13760
2	5,774,342	515,310	411,848	1,281,652	4,927,842	4,875,861	.10457	.08436	.08734	.09510
3	3,566,032	203,100	158,650	1,172,738	2,899,840	2,877,615	.07004	.05513	.06740	.06791
4	2,030,549	70,670	82,050	778,749	1,600,149	1,605,839	.04416	.05109	.04850	.04981
5	1,099,080	21,000	30,450	446,360	860,675	865,400	.02440	.03519	.03348	.03936
6	601,270	9,100	17,500	194,270	495,385	499,535	.01837	.03503	.02373	.03555
7	380,400	6,000	15,800	162,300	291,350	295,250	.02746	.05351	.01761	.03600
8	194,300	2,200	2,000	132,900	126,850	125,750	.01734	.01578	.01172	.03812
9	57,200	0	2,200	85,000	38,600	39,700	0	.05542	.00591	.04518
10	20,000	0	0	19,000	10,500	10,500	0	0	.00193	.05301
11	1,000	0	0	1,000	500	500	0	0	0	0
Total	23,809,934	1,571,515	1,987,081	6,527,165	19,552,810	19,760,593				

TABLE IV

Mortality Assumption After Ten Years	Interest Rate	Net Single Premium		Total
		First Ten Years	Succeeding Years	
Experience by Lives, all Ages and both Sexes Combined Average Age at Approval of Disability Claim 46				
Hunter's	2½%	$352.30	$195.71	$548.01
	3	346.81	177.12	523.93
A M (5)	2½	352.30	173.04	525.34
	3	346.81	153.00	499.81
C S O	2½	352.30	172.41	524.71
	3	346.81	152.36	499.17
Experience by Amounts, all Ages and both Sexes Combined Average Age at Approval of Disability Claim 47				
Hunter's	2½%	$346.46	$210.99	$557.45
	3	341.04	191.21	532.25
A M (5)	2½	346.46	187.98	534.44
	3	341.04	166.68	507.72
C S O	2½	346.46	187.24	533.70
	3	341.04	165.92	506.96

TABLE V

Disability Claim Reserves per $1,000 of Insurance Assuming Hunter's Ultimate Mortality Rates after 10 Years

Duration	Experience by Amounts		Experience by Lives	
	2½%	3%	2½%	3%
0	$557	$532	$548	$524
1	567	537	555	527
2	594	560	579	547
3	624	588	608	574
4	654	616	638	601
5	680	641	666	628
6	703	664	691	652
7	724	685	713	675
8	740	702	732	694
9	752	715	745	707
10	760	723	754	716

and 47 by amounts. Therefore, the average age at the beginning of the 10th disability year was assumed to be 55 and 56, respectively. In the graduation, the death rates were graded smoothly into Hunter's ultimate death rates at those ages. The assumptions as to the average ages at the 10th year of disability might be open to some question if there were a significant variation in the age at approval between the existing and the terminated by recovery or death, but the data was too limited to permit investigation of this point. In any event, a deviation of a year or so in age would have little effect on the results.

A tabulation of the average age at approval by calendar year of disability did show a definite upward trend in the average age. This trend can be expected to continue until the experience under group life insurance policies with waiver of premium benefits becomes fully mature.

Table II exhibits this experience by lives and Table III by amounts. These tables show for each duration of disability the deaths, recoveries, existing, exposures, and the crude and graduated rates of recovery and death.

D. Value at Date of Approval

The graduated death and recovery rates shown in Tables II and III were used to construct double decrement tables for the first 10 years following approval of disability claim. Commutation columns were also constructed based on three different assumptions as to mortality after the first 10 years of disability and with the use of 2½% and 3% interest rates.

1. Hunter's ultimate mortality rates referred to above.
2. American Men Ultimate Table of Mortality.
3. Commissioners Standard Ordinary Mortality Table.

Net single premiums at date of approval were computed from the graduated data per $1,000 of benefit payable in the event of death while disabled. The value of the coverage for the first 10 years of disability represents the major portion of the cost of the benefit so that, as Table IV shows, the mortality basis assumed for deaths after 10 years does not influence the total single premiums greatly.

In order to test for any bias introduced by the graduation, the above single premiums were also computed using the ungraduated data. The ungraduated totals were about 1% smaller than the graduated values.

An analysis of the data by sex indicated that, for females, the net single premium at time of approval of disability claim for a benefit payable in the event of death during disability, would be considerably lower than $500. However, inasmuch as around 40% of the experience was on lives uncoded by sex, and the experience on lives coded "female" was only around 12% of the total experience, it was not felt that sufficient data was at hand to warrant the publication of separate figures for males and females.

GROUP LIFE WAIVER OF PREMIUM EXPERIENCE

E. Reserves

Reserves for the first 10 years after approval of disability were computed at 2½% and 3% interest, using the graduated mortality and recovery rates and Hunter's ultimate death rates and appear in Table V. Hunter's ultimate reserves can be used for consistent factors for higher durations.

Appendix F

Robert I. Mehr (Rev. Ed.)
Life Insurance: Theory and Practice

The newest ordinary life table is the 1958 Commissioners Standard Ordinary Table developed by the National Association of Insurance Commissioners and the Society of Actuaries. While impetus for work on the table grew from the deficiency reserve problem, the Industry Advisory Committee to the NAIC's Subcommittee on Deficiency Reserves and Mortality Tables Review concluded that the need for a new mortality table existed regardless of the deficiency reserve problem. It reported that the 1941 CSO Table was less representative of current experience than the American Experience Table had been at the time the 1941 CSO Table was developed.

The 1958 CSO Table was developed from a morality table called X_{17} devised by the Society of Actuaries from the 17th computer run on the data and their modifications. The underlying data are the combined ultimate mortality experience on $170 billion of standard ordinary insurance of 15 large insurers between 1950 and 1954 and involved death claims of nearly $2 billion. The basic table is a graduated mortality table constructed from these data. The unadjusted death rates at the young adult ages were less than half of those used for the 1941 CSO Table, and never more than 81 percent of the earlier rates.

The basic unadjusted mortality table was compared with individual insurer experience to study deviations. The ratio of actual to projected deaths ranged from 65.3 percent for the insurer with the best experience to 115.7 percent for the insurer with the worst experience. Because rates representing average experience (without safety margins) would be inappropriate for a mortality table used by all insurers in determining policy reserves, a safety margin ranging from a low of 15 percent (ages 64-93) to a high of 236.1 percent (age 10) was adopted.

Supplemental Brief

Office - Supreme Court, U.S.
FILED
JUN 11 1982
ALEXANDER L. STEVAS,
CLERK

No. 81-1791

In the
Supreme Court of the United States
OCTOBER TERM, 1981

GROUP LIFE AND HEALTH INSURANCE COMPANY,
Petitioner,

v.

UNITED STATES OF AMERICA,
Respondent.

SUPPLEMENTAL BRIEF

BRIEF IN SUPPORT OF PETITIONER'S PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT, UNIT A

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No. 81-1791

In the

Supreme Court of the United States

OCTOBER TERM, 1981

GROUP LIFE AND HEALTH INSURANCE COMPANY,
Petitioner,

v.

UNITED STATES OF AMERICA,
Respondent.

BRIEF IN SUPPORT OF PETITIONER'S PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT, UNIT A

After Petitioner had filed its Petition for Writ of Certiorari on March 27, 1982, this Court decided the case of *Pullman-Standard v. Swint*, —— U. S. ——, on April 27, 1982, a copy of which is attached as Appendix A, (without dissenting opinions) Docket Nos. 80-1190 and 80-1193. In accordance with Paragraph 6 of this Court's Rule 22, Petitioner files this brief calling the attention of the Court to the above case whose holding applies to both issues in this case.

In the *Pullman-Standard* case, this Court held that if the Court of Appeals for the Fifth Circuit in deciding a case followed what seems to be the accepted rule in that Circuit, its judgment must be reversed. The accepted rule referred

to is the practice by the Fifth Circuit of making independent factual determinations without remanding such questions to the district court for such a decision. (App. A-12) This Court expressly pointed out in the *Pullman-Standard* case that where an appellate court discerns that a district court has failed to make a finding because of an erroneous view of the law or where findings are infirm because of an erroneous view of the law, the appellate court should remand the case to the district court for further proceedings to permit the trial court to make the missing findings. This Court expressly held that fact finding is the basic responsibility of district courts rather than appellate courts and that courts of appeal should not resolve, in the first instance, factual disputes which have not been considered by the district court (citing *DeMarco* v. *United States*, 415 U. S. 449, 450n. (1974)), and that where a trial court fails to make findings, or to find on a material issue and an appeal is taken, the appellate court will normally vacate the judgment and remand the action for appropriate findings to be made (citing 5A J. Moore & J. Lucas, Moore's Federal Practice Sec. 52.06[2] (1981)). (App. A-17) This the Court of Appeals for the Fifth Circuit failed to do in this case with regard to both issues and failed to properly apply the clearly erroneous standard of Rule 52.

With respect to the life insurance company issue, the Fifth Circuit held that the district court had made an error of law; *i.e.*, only Table V of the 1949 Report would qualify as a recognized mortality or morbidity table under Section 801(b), Internal Revenue Code which provided that life reserves must, inter alia, be computed or estimated using recognized tables. After such a determination is made by an appellate court that the district court has made such an error, the case should be remanded to the district court to allow that court to correct its legal

mistake and make additional findings of fact with respect to the correct legal standard. Not only did the Court of Appeals refuse to do this, after announcing the error of law it held as a matter of law that it was unable to do this because the original reserve figure "must have been an estimate, calculated in advance, based on mortality tables and rates of interest." (Footnote 16, Court of Appeals' Opinion — See Appendix C-33 of Petition for Writ of Certiorari filed in this case). As pointed out in Petitioner's Petition for Writ of Certiorari, the Court of Appeals held that the correct way to determine the disability-disabled lives reserve in this case was to take the period of disability of each of Petitioner's 23 disabled insureds for the year 1967 and take the appropriate reserve factor from Table V of the 1949 Report and compute the correct reserve. This is a pure fact determination since both the period of disability of each of Petitioner's 23 disabled insureds was in evidence as was Table V of the 1949 Report and the case should have been remanded to the district court in accordance with this Court's decision in *Pullman-Standard* v. *Swint*.

The Court of Appeals for the Fifth Circuit clearly erred when it held that it was legally constrained to do this. This Court enunciated the contrary rule in the *Pullman-Standard* case. Where an error of law has been committed (as here) by the district court, the case should be remanded to that court to correct that error and make additional fact findings if necessary. Once the Court of Appeals decided that the district court erred in using the $750/$1,000 reserve figure and announced that the correct method for determining the reserve was the use of Table V in the 1949 Report, it was required to remand this case to the district court for the factual determination of whether Petitioner qualified as a life insurance company after the reserve was computed using the new standard.

That the issue is factual and that the calculation is not required to be made in advance is clearly supported by the decision of the Court of Claims in *Central National Life Insurance Company of Omaha v. United States* 574 F2d 1067 (Ct.Cl., 1978). The Court of Claims in that case held that the initial reserve calculated on the basis of gross unearned premiums qualified as a life reserve under Section 801(b) if existing mortality or morbidity tables support the reasonableness of such reserve or if the reserve actually established could include a qualifying lesser amount. There is no legal or equitable requirement that the amount of the reserve must be precisely and accurately computed in advance when it was not known until the decision of the Fifth Circuit how the reserve should be calculated. If an error has been committed, the district court should be given an opportunity to correct it.

Following what seems to be the accepted rule in the Fifth Circuit (*Pullman-Standard* v. *Swant*, *App* A-12, Footnote 16), the Court below in a lengthy opinion, under the guise of applying the clearly erroneous standard, made many other determinations of pure fact issues which had not been considered by the district court. It is a question of pure fact as to whether the $750/$1,000 industry-wide estimate is based on the 1949 Report and, if there is any ambiguity about this, it should have been remanded to the district court for a determination. It is also a question of pure fact as to whether Section I of the 1949 Report does recommend the use of the $750/$1,000 factor even though the experience data of Table V of the 1949 Report disclosed that actual experience was lower.

The Court of Appeals incorrectly decided the second issue in this case involving the question of whether an informal claim for refund had been filed. The Court of Appeals could only reverse the district court's finding that an informal claim for refund had been filed and that the Commissioner

had waived compliance with formalities by allowing the claims by concluding that such a holding was clearly erroneous under Rule 52(a). In its discussion of this second issue and its decision thereon, the Court of Appeals for the Fifth Circuit did not purport to correct a legal error nor did it refer to or expressly apply the clearly erroneous standard of Rule 52(a) nor did it expressly decide that the holding of the district court was clearly erroneous. It made an independent factual determination and substituted its opinion on a pure factual issue for the factual findings of the court below; namely, that Petitioner filed an informal claim which was allowed by the Commissioner and he thereby waived formal compliance with Section 6511, Internal Revenue Code.

Petitioner also calls this Court's attention to its very recent decision (*Ives Laboratories, Inc.* v. *Inwood Laboratories, Inc., and others,* —— U. S. —— (1982)), involving six generic drug makers wherein this Court held that the Court of Appeals for the Second Circuit had improperly substituted its judgment of the facts in the case for that rendered earlier by the district court. The principles of this case would also be applicable here.

CONCLUSION

For the reasons stated herein and in Petitioner's Petition for Writ of Certiorari the Petition for Writ of Certiorari should be granted.

Respectfully submitted,

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Appendix

Appendix A

Supreme Court of the United States

Nos. 80-1190 and 80-1193

PULLMAN-STANDARD, A DIVISION OF PULLMAN, INCORPORATED,

Petitioner,

v.

80-1190

LOUIS SWINT AND WILLIE JOHNSON, ETC. UNITED STEELWORKERS OF AMERICA, ALF-CIO, ET AL.

Petitioners

v.

80-1193

LOUIS SWINT AND WILLIE JAMES JOHNSON

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

[April 27, 1982]

JUSTICE WHITE delivered the opinion of the Court.

Respondents were black employees at the Bessemer, Alabama plant of petitioner, Pullman-Standard (the "company"), a manufacturer of railway freight cars and parts. They brought suit against the company and the union petitioners — the United Steelworkers of America, AFL-CIO-CLC, and its Local 1466 (collectively "USW") — alleging violations of Title VII oi the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq.* and 42 U. S. C. 1981.[1] As they come

[1]In their original complaint, besides challenging the seniority system discussed in this opinion, plaintiffs also alleged discrimination in job assignments, promotions, and the failure to post publicly a list of changes in assignments. These were all brought as "class" issues. Two charges of individual discrimination were also brought.

here, these cases involve only the validity, under Title VII, of a seniority system maintained by the Company and USW. The District Court found "that the differences in terms, conditions or privileges of employment resulting [from the seniority system] are 'not the result of an intention to discriminate' because of race or color," App. to Pet'n. for Cert. in No. 80-1190, p. A-147 (hereinafter App.), and held, therefore, that the system satisfied the requirements of § 703(h) of the Act. The Court of Appeals for the Fifth Circuit reversed:

> "Because we find that the differences in the terms, conditions and standards of employment for black workers and white workers at Pullman-Standard resulted from an intent to discriminate because of race, we hold that the system is not legally valid under section 703(h) of Title VII, 42 U. S. C. 2000e-2(h)." *Swint* v. *Pullman-Standard*, 624 F. 2d 525, 533-534 (1980).

We granted the petitions for certiorari filed by the USW and by the Company, —— U. S. ——, limited to the first question presented in each petition: whether a Court of Appeals is bound by the "clearly erroneous" rule of Fed. Rules Civ. Proc. 52(a) in reviewing a District Court's findings of fact, arrived at after a lengthy trial, as to the motivation of the parties who negotiated a seniority system; and whether the court below applied wrong legal criteria in determining the *bona fides* of the seniority system. We conclude that the Court of Appeals erred in the course of it review and accordingly reverse its judgment and remand for further proceedings.

I

Title VII is a broad remedial measure, designed "to assure equality of employment opportunities." *McDonnell Douglas Corp. v. Green*, 411 U. S. 792, 800 (1973). The Act was designed to bar not only overt employment discrimination,

---

The Court of Appeals held that Pullman-Standard had violated Title VII in making job assignments and in selecting foremen. In granting certiorari, we declined to review those aspects of the decision.

"but also practices that are fair in form, but discriminatory in operation." *Griggs* v. *Duke Power Co.*, 401 U. S. 424, 431 (1971). "Thus, the Court has repeatedly held that a prima facie Title VII violation may be established by policies or practices that are neutral on their face and in intent but that nonetheless discriminate in effect against a particular group." *Teamsters* v. *United States*, 431 U. S. 324, 349 (1977) (hereinafter *Teamsters*). The Act's treatment of seniority systems, however, establishes an exception to these general principles. Section 703(h) provides in pertinent part:

> "Notwithstanding any other provision of this subchapter, it shall not be an unlawful employment practice for an employer to apply different standards of compensation, or different terms, conditions or privileges of employment pursuant to a bona fide seniority . . . system . . . provided that such differences are not the result of an intention to discriminate because of race."

Under this section, a showing of disparate impact is insufficient to invalidate a seniority system, even though the result may be to perpetuate pre-Act discrimination. In *Trans World Airlines, Inc.* v. *Hardison*, 432 U. S. 63, 82 (1977), we summarized the effect of § 703(h) as follows: "[A]bsent a discriminatory purpose, the operation of a seniority system cannot be an unlawful employment practice even if the system has some discriminatory consequences." Thus, any challenge to a seniority system under Title VII will require a trial on the issue of discriminatory intent: Was the system adopted because of its racially discriminatory impact?

This is precisely what happened in this case. Following our decision in *Teamsters*, the District Court held a new trial on the limited question of whether the seniority system was "instituted or maintained contrary to Section 703(h) of the new Civil Rights Act of 1964." App. A-125.[2] That court

[2]The procedural history of this case is rather complex. The original complaint was filed in 1971. Since that time the case has been tried three times and has twice been reviewed by the Court of Appeals.

concluded, as we noted above and will discuss below, that the system was adopted and maintained for purposes wholly independent of any discriminatory intent. The Court of Appeals for the Fifth Circuit reversed.

II

Petitioners submit that the Court of Appeals failed to comply with the command of Rule 52 that the findings of fact of a district court may not be set aside unless clearly erroneous. We first describe the findings of the District Court and the Court of Appeals.

Certain facts are common ground for both the District Court and the Court of Appeals. The company's Bessemer plant was unionized in the early 1940's. Both before and after unionization, the plant was divided into a number of different operational departments.[3] USW sought to represent all production and maintenance employees at the plant and was elected in 1941 as the bargaining representative of a bargaining unit consisting of most of these employees. At that same time, the International Association of Machinists and Aerospace Workers ("IAM") became the bargaining representative of a unit consisting of five departments.[4] Between 1941 and 1944, IAM ceded certain workers in its bargaining unit to USW. As a result of this transfer, the IAM bargaining unit became all white.

Throughout the period of representation by USW, the plant was approximately half black. Prior to 1965, the Company openly pursued a racially discriminatory policy of job assignments. Most departments contained more than one job category and as a result most departments were racially

[3]In 1941, prior to unionization, the Bessemer plant was divided into 20 departments. By 1954, there were 28 departments — 26 USW units and 2 IAM units. The departments remained essentially unchanged after 1954.

[4]The International Brotherhood of Electrical Workers ("IBEW") gained representation status for two small departments. The IBEW unit was all white. IBEW, however was decertified in 1946 and its members were reabsorbed into a department represented by USW.

mixed. There were no lines of progression or promotion within departments.

The seniority system at issue here was adopted in 1954.[5] Under that agreement, seniority was measured by length of continuous service in a particular department.[6] Seniority was originally exercised only for purposes of layoffs and hirings within particular departments. In 1956 seniority was formally recognized for promotional purposes as well. Again, however, seniority, with limited exceptions, was only exercised within departments; employees transferring to new departments forfeited their seniority. This seniority system remained virtually unchanged until after this suit was brought in 1971.[7]

The District Court approached the question of discriminatory intent in the manner suggested by the Fifth Circuit in *James* v. *Stockham Valves & Fittings Co.*, 559 F. 2d 310 (1977). There, the Court of Appeals stated that under *Teamsters* "the totality of the circumstances in the development and maintenance of the system is relevant to examining that issue." *Id.*, at 352. There were, in its view, however, four particular factors that a court should focus on.[8]

[5]A departmental seniority system was part of the initial collective bargaining agreement between the company and USW in 1942. Between 1947 and 1954, however, the seniority system changed from one based on departments to one based upon particular occupations within departments. In 1954, the system went back to a departmental base.

[6]The only exceptions, until 1972 (see n. 7), were for employees transfering at the request of the company or for those electing transfer in lieu of lay-off.

[7]In 1972, the company entered into an agreement with the Department of Labor to bring its employment practices into compliance with Executive Order 11246. This provided an exception to the departmental limit on seniority, allowing, certain black employees to make inter-departmental transfers without any loss of seniority.

[8]The Fifth Circuit relied upon the following passage in *Teamsters* v. *United States*, 431 U. S. 324, 355-356 (1977):

"The seniority system in this litigation is entirely bona fide. It applies equally to all races and ethnic groups. To the extent that it 'locks' employees into non-line-driver jobs, it does so far all. . . .

First, a court must determine whether the system "operates to discourage all employees equally from transferring between seniority units." *Ibid.* The District Court held that the system here "was facially neutral and . . . was applied equally to all races and ethnic groups." App. A-132. Although there were charges of racial discrimination in its application, the court held that these were "not substantiated by the evidence." *Id.*, at 133. It concluded that the system "applied equally and uniformly to all employees, black and white, and that given the approximately equal number of employees of the two groups, it was quantitatively neutral as well." *Id.*, at 134.[9]

Second, a court must examine the rationality of the departmental structure, upon which the seniority system relies, in light of the general industry practice. *James, supra,* at 352. The District Court found that linking seniority to "departmental age" was "the modal form of agreements generally, as well as with manufacturers of railroad equipment in particular." App. A-137. Furthermore, it found the basic arrangement of departments at the plant to be rationally related to the nature of the work and to be "consistent with practices which were . . . generally followed at other unionized plants throughout the country." *Id., at* 136-37. While questions could be raised about the necessity of certain departmental divisions, it found that all of the challenged lines of division grew out of historical circumstances

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The placing of line drivers in a separate bargaining unit from other employees is rational, in accord with the industry practice, and consistent with National Labor Relation Board precedents. It is conceded that that seniority system did not have its genesis in racial discrimination, and that it was negotiated and has been maintained free from any illegal purpose."

This passage was of course not meant to be an exhaustive list of all the factors that a district court might or should consider in making a finding of discriminatory intent.

[9]The court specifically declined to make any finding on whether the no-transfer provision of the seniority system had a greater relative effect on blacks than on whites, because of qualitative differences in the departments in which they were concentrated. It believed that such an inquiry would have been inconsistent with the earlier Fifth Circuit opinion in this case.

at the plant that were unrelated to racial discrimination.[10] Although unionization did produce an all white IAM bargaining unit, it found that USW "cannot be charged with racial bias in its response to the IAM situation. [USW] sought to represent all workers, black and white, in the plant." *Id.*, at 147. Nor could the company be charged with any racial discrimination that may have existed in IAM:

> "The company properly took a 'hands-off' approach towards the establishment of the election units . . . It bargained with those unions which were afforded representational status by the NLRB and did so without any discriminatory animus." *Id.*, at 146.

Third, a court had to consider "whether the seniority system had its genesis in racial discrimination," *James, supra*, at 352, by which it meant the relationship between the system and other racially discriminatory practices. Although finding ample discrimination by the company in its employment practices and some discriminatory practices by the union,[11] the District Court concluded that the seniority system was in no way related to the discriminatory practices:

> "The seniority system . . . had its genesis . . . at a period when racial segregation was certainly being practiced; but this system was not itself the product of this bias. The system rather came about as a result of colorblind objectives of a union which — unlike most structures and institutions of the area — was not an arm of a segregated society. Nor did it foster the discrimination . . . which was being practiced by custom in the plant." App. A-144.

[10] In particular, the court focused on the history of the unionization process at the plant and found certain of the departmental divisions to be based on the evolving relationship between USW and IAM.

[11] With respect to USW, the District Court found that "[u]nion meetings were conducted with different sides of the hall for white and black members, and social functions of the union were also segregated." It also found, however, that "[w]hile possessing some of the trappings taken from an otherwise segregated society, the USW local was one of the few institutions in the area which did not function in fact to foster and maintain segregation; rather, it served a joint interest of white and black workers which had a higher priority than racial considerations."

Finally, a court must consider "whether the system was negotiated and has been maintained free from any illegal purpose." *James*, *supra*, at 352. Stating that it had "carefully considered the detailed record of negotiation sessions and contracts which span a period of some thirty-five years," App. A-146, the court found that the system was untainted by any discriminatory purpose. Thus, although the District Court focused on particular factors in carrying out the analysis required by § 703(h), it also looked to the entire record and to the "totality of the system under attack." *Id.*, at 147.

The Court of Appeals addressed each of the four factors of the *James* test and reached the opposite conclusion. First, it held that the District Court erred in putting aside qualitative differences between the departments in which blacks were concentrated and those dominated by whites, in considering whether the system applied "equally" to whites and blacks.[12] This is a purported correction of a legal standard under which the evidence is to be evaluated.

Second, it rejected the District Court's conclusion that the structure of departments was rational, in line with industry practice, and did not reflect any discriminatory intent. Its discussion is brief but focuses on the role of IAM and certain characteristics unique to the Bessemer plant. The court concluded:

> "The record evidence, generally, indicates arbitrary creation of the departments by the company since unionization and an attendant adverse affect on black workers. The individual differences between the departmental

[12]It does not appear to us that the District Court actually found a qualitative difference but held it to be irrelevant. The relevant passage of the District Court opinion read as follows: "By ranking the twenty-eight USW and IAM departments according to some perceived order of desirability, one could . . . attempt to measure the relative effect of the no-transfer rule on white and black employees . . . . It may well be that a somewhat greater impact was felt by blacks than whites although . . . this conclusion is by no means certain." App. A-134.

> structure at Pullman-Standard and that of other plants, and as compared with industry practice, are indicative of attempts to maintain one-race departments." 624 F. 2d, at 532.

In reaching this conclusion, the Court of Appeals did not purport to be correcting a legal error, nor did it refer to or expressly apply the clearly erroneous standard.

Third, in considering the "genesis" of the system, the Court of Appeals held that the District Court erred in holding that the motives of IAM were not relevant.[13] This was the correction of a legal error on the part of the District Court in excluding relevant evidence. The court did not stop there, however. It went on to hold that IAM was acting out of discriminatory intent — an issue specifically not reached by the District Court — and that "considerations of race permeated the negotiation and adoption of the seniority system in 1941 and subsequent negotiations thereafter." 624 F. 2d, at 532.

Fourth, despite this conclusion under the third *James* factor the Court of Appeals then recited, but did not expressly set aside or find clearly erroneous, the District Court's findings with respect to the negotiation and maintenance of the seniority system.

The court then announced that "having carefully reviewed the evidence offered to show whether the departmental seniority system in the present case is 'bona fide' within the meaning of § 703(h) of Title VII, we reject the District Court's finding." *Id.*, at 533. Elaborating on its disagreement, the Court of Appeals stated:

> "An analysis of the totality of the facts and circumstances surrounding the creation and continuance of the

[13] The original complaint in this case did not mention IAM. Prior to the first trial, respondents sought and received leave to amend their complaint to add IAM as a Rule 19 defendant, "insofar as the relief requested may involved or infringe upon the provisions of such Union's collective bargaining agreement with the Company." Order of the District Court, June 4, 1974 (Joint Appendix 29).

> departmental system at Pullman-Standard leaves us with the definite and firm conviction that a mistake has been made. There is no doubt, based upon the record in this case, about the existence of a discriminatory purpose. The obvious principal aim of the I.A.M. in 1941 was to exclude black workers from its bargaining unit. That goal was ultimately reached when maneuvers by the I.A.M. and U.S.W. resulted in an all-white I.A.M. unit. The U.S.W., in the interest of increased membership, acquiesced in the discrimination while succeeding in significantly segregating the departments within its own unit
>
> The district court might have reached a different conclusion had it given the I.A.M.'s role in the creation and establishment of the seniority system its due consideration." *Ibid.*

Having rejected the District Court's finding, the court made its own findings as to whether the USW seniority system was protected by § 703(h):

> "We consider significant in our decision the manner by which the two seniority units were set up, the creation of the various all-white and all-black departments within the U.S.W. unit at the time of certification and in the years thereafter, conditions of racial discrimination which affected the negotiation and renegotiation of the system, and the extent to which the system and the attendant no-transfer rule locked blacks into the least remunerative positions within the company. Because we find that the differences in the terms, conditions and standards of employment for black workers and white workers at Pullman-Standard resulted from an intent to discriminate because of race, we hold that the system is not legally valid under section 703(h) of Title VII, 42 U. S. C. § 2000e-2(h)." *Id.*, at 533-534.

In connection with its assertion that it was convinced that a mistake had been made, the Court of Appeals, in a footnote, referred to the clearly erroneous standard of Rule 52(a).

Id., at 533 n. 6.[14] It pointed out, however, that if findings "are made under an erroneous view of controlling legal principles, the clearly erroneous rule does not apply, and the findings may not stand." Finally, quoting from *East* v. *Romine, Inc.*, 518 F. 2d 332, 339 (CA5 1975), the Court of Appeals repeated the following view of its appellate function in Title VII cases where purposeful discrimination is at issue:

> "Although discrimination *vel non* is essentially a question of fact it is, at the same time, the ultimate issue for resolution in this case, being expressly proscribed by 42 U. S. C. A. § 2000e-2(a). As such, a finding of discrimination or non-discrimination is a finding of ultimate fact. [Cities omitted.] In reviewing the district court's findings, therefore, we will proceed to make an independent determination of appellant's allegations of discrimination, though bound by findings of subsidiary fact which are themselves not clearly erroneous."

III

Pointing to the above statement of the Court of Appeals and to similar statements in other Title VII cases coming from that court,[15] petitioners submit that the Court of Ap-

[14] In *United States v. Gypsum Co.* 333 U. S. 364, 395 (1948), this Court characterized the clearly erroneous standard as follows: "A finding is 'clearly erroneous' when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed." We note that the Court of Appeals quoted this passage at the conclusion of its analysis of the District Court opinion. *Supra*, at 10.

[15] See *Jackson* v. *City of Kileen*, 654 F. 2d 1181, 1184 (1981); *Payne* v. *McLemore's Wholesale & Retail Stores*, 654 F. 2d 1130, 1147 (1981); *Wilkins* v. *University of Houston*, 654 F. 2d 388, 390 (1981); *Lindsey v. Miss. Research & Development Center*, 652 F. 2d488, 492 (1981); *Rohde v. K.O. Steel Castings, Inc.*, 649 F. 2d 317, 320 (1981); *Joshi v. Florida State University*, 646 F. 2d 981, 986 (1981); *Phillips v. Joint Legislative Com., etc.* 637 F. 2d 1014, 1024 (1981); *Danner v. United States Civil Serv. Com'n*, 635 F. 2d 427, 430-431 (1981); *Thompson v. Leland Police Dept*, 633 F. 2d 1111, 1112 (1980); *Crawford v. Western Electric Co., Inc.*, 614 F. 2d 1300, 1311 (1980); *Burdine v. Texas Dept. of Community Affairs*, 608 F. 2d 563, 566 (1979); *Williams* v. *Tallahassee Motors, Inc.* 607 F. 2d 689, 690 (1979); *Parson* v. *Kaiser Aluminum & Chemical Corp.*, 575 F. 2d 1374, 1382 (1978); *Causey* v. *Ford Motor Co.*, 516 F. 2d 416, 420-421 (1975); *East v. Romine, Inc.*, 518 F. 2d 332, 338-339 (1975).

peals made an independent determination of discriminatory purpose, the "ultimate fact" in this case, and that this was error under Rule 52. We agree with petitioners that if the Court of Appeals followed what seems to be the accepted rule in that circiut, its judgment must be reversed.[16]

[16]There is some indication in the opinions of the Court of Appeals for the Fifth Circuit (see no. 14) that the circuit rule with respect to "ultimate facts" is only another way of stating a standard of review with respect to mixed questions of law and fact — the ultimate "fact" is the statutory, legally determinative consideration (here, intentional discrimination) which is or is not satisfied by subsidiary facts admitted or found by the trier of fact. As indicated in the text, however, the question of intentional discrimination under § 703(h) is a pure question of fact. Furthermore, the Court of Appeals' opinion in this case appears to address the issue as a question of fact unmixed with legal considerations.

At the same time, this Court has on occasion itself indicated that findings on "ultimate facts" are independently reviewable. In *Baumgartner* v. *United States*, 322 U. S. 665 (1944), the issue was whether or not the findings of the two lower courts satisfied the clear and convincing standard of proof necessary to sustain a denaturalization decree. The Court held that the conclusion of the two lower courts that the exacting standard of proof had been satisfied was not an unreviewable finding of fact but one that a reviewing court could independently assess. The Court referred to the finding as one of "ultimate" fact, which in that case involved an appraisal of the strength of the entire body of evidence. The Court said that the significance of the clear and convincing proof standard "would be lost" if the ascertainment by the lower courts whether that exacting standard of proof had been satisfied on the whole record were to be deemed a "fact" of the same order as all other "facts not open to review here". 322 U. S., at 671.

The Fifth Circuit's rule on appellate consideration of "ultimate facts" has its roots in this discussion in *Baumgartner*. In *Galena Oaks Corp.* v. *Scofield*, 218 F. 2d 217 (CA5 1954), in which the question was whether the gain derived from the sale of a number of houses was to be treated as capital gain or ordinary income, the Court of Appeals reiled directly on *Baumgartner* in holding that this was an issue of "ultimate fact" that an appellate court may review free of the clearly erroneous rule, *Causey v. Ford Motor Co.*, 516 F. 2d 416 (CA5 1975), relying on *Galena Oaks Corp.* v. *Scofield*, *supra*, said that "although discrimination *vel non* is essentially a question of fact, it is, at the same time, the ultimate issue for resolution in this case" and as such, was deemed to be independently

Rule 52 broadly requires that findings of fact not be set aside unless clearly erroneous. It does not make exceptions or purport to exclude certain categories of factual findings from the obligation of a Court of Appeals to accept a district court's findings unless clearly erroneous. It does not divide facts into categories; in particular, it does not divide findings of fact into those that deal with "ultimate" and those that deal with "subsidiary" facts.

The rule does not apply to conclusions of law. The Court of Appeals, therefore, was quite right in saying that if a District Court's findings rest on an erroneous view of the law, they may be set aside on that basis. But here the District Court was not faulted for misunderstanding or applying an erroneous definition of intentional discrimination.[17] It was reversed for arriving at what the Court of Appeals thought was an erroneous finding as to whether the differential impact of the seniority system reflected an intent to discriminate on account of race. That question, as we see it, is a pure question of fact, subject to Rule 52's clearly erroneous standard. It is not a question of law and not a mixed question of law and fact.

The Court has previously noted the vexing nature of the distinction between questions of fact and questions of law. See *Baumgartner* v. *United States*, 322 U. S. 665, 671 (1944).

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reviewable. The passage from *East v. Romine, Inc.*, 518 F. 2d 332, 339 (CA5 1975), which was repeated in the case before us now, *supra*, at 11 rested on the opinion in *Causey v. Ford Motor Co.*

Whatever *Baumgartner* may have meant by its discussion of "ultimate facts", it surely did not mean that whenever the result in a case turns on a factual finding, an appellate court need not remain within the constraints of Rule 52. *Baumgartner's* discussion of "ultimate facts" referred not to pure findings of fact — as we find discriminatory intent to be in this context — but to findings that "clearly impl[y] the application of standards of law." 322 U. S., at 671.

[17]As we noted above, the Court of Appeals did at certain points purport to correct what it viewed as legal errors on the part of the District Court. The presence of such legal errors may justify a remand by the Court of Appeals to the District Court for additional fact finding under the correct legal standard. *Infra*, at 17-18.

Rule 52 does not furnish particular guidance with respect to distinguishing law from fact. Nor do we yet know of any other rule or principle that will unerringly distinguish a factual finding from a legal conclusion. For the reasons that follow, however, we have little doubt about the factual nature of §703(h)'s requirement that a seniority system be free of an intent to discriminate.

Treating issues of intent as factual matters for the trier of fact is commonplace. In *Dayton Board of Education* v. *Brinkman*, 443 U. S. 526, 534 (1979), the principal question was whether the defendants had intentionally maintained a racially segregated school system at a specified time in the past. We recognized that issue as essentially factual, subject to the clearly erroneous rule. In *Comm'r* v. *Duberstein*, 363 U. S. 278 (1960), the Court held that the principal criterion for identifying a gift under the applicable provision of the Internal Revenue Code was the intent or motive of the donor — "one that inquires what the basic reason for his conduct was in fact." 363 U. S., at 286. Resolution of that issue determined the ultimate issue of whether a gift had been made. Both issues were held to be questions of fact subject to the clearly erroneous rule. In *United States* v. *Yellow Cab*, 338 U. S. 338, 341 (1949), an antitrust case, the Court referred to "findings as to the design, motive and intent with which men act" as peculiarly factual issues for the trier of fact and therefore subject to appellate review under Rule 52.

Justice Black's dissent in *Yellow Cab* suggested a contrary approach. Relying on *United States v. Griffith*, 334 U. S. 100 (1948) he argued that it is not always necessary to prove "specific intent" to restrain trade; it is enough if a restraint is the result or consequence of a defendant's conduct or business arrangements. Such an approach, however, is specifically precluded by § 703(h) in Title VII cases challenging seniority systems. Differentials among employees that result from a seniority system are not unlawful employment practices unless the product of an intent to discriminate. It would make no sense, therefore, to say that the

intent to discriminate required by § 703(h) may be presumed from such an impact. As § 703(h) was construed in *Teamsters*, there must be a finding of actual intent to discriminate on racial grounds on the part of those who negotiated or maintained the system. That finding appears to use to be a pure question of fact.

This is not to say that discriminatory impact is not part of the evidence to be considered by the trial court in reaching a finding on whether there was such a discriminatory intent as a factual matter.[18] We do assert, however, that under § 703(h) discriminatory intent is a finding of fact to be made by the trial court; it is not a question of law and not a mixed question of law and fact of the kind that in some cases may allow an appellate court to review the facts to see if they satisfy some legal concept of discriminatory intent.[19] Discriminatory intent here means actual motive; it is not a legal presumption to be drawn from a factual showing of something less than actual motive. Thus, a court of appeals

[18]See, *e. g.*, *Furnco Construction Corp.* v. *Waters*, 438 U. S. 567, 580 (1978): "Proof that [an employer's] work force was racially balanced or that it contained a disproportionately high percentage of minority employees is not wholly irrelevant on the issue of intent when that issue is yet to be decided."

[19]We need not, therefore, address the much-mooted issue of the applicability of the Rule 52(a) standard to mixed questions of law and fact — i. e., questions in which the historical facts are admitted or established, the rule of law is undisputed, and the issue is whether the facts satisfy the statutory standard, or to put it another way, whether the rule of law as applied to the established facts is or is not violated. There is substantial authority in the circuits on both sides of this question. Compare *Johnson v. Johnson*, 531 F. 2d 169, 174 n. 12 (CA3 1976); *Stafos* v. *Jarvis*, 477 F. 2d 369, 372 (CA10 1973); [and] *Johnson* v. *Salisbury*, 448 F. 2d 374, 377 (CA6 1971), *with Rogers v. Bates*, 431 F. 2d 16, 18 (CA8 1970); [*and*] *Pennsylvania Gas Co. v. McCoy*, 167 F. 2d 132, 122 (CA5 1948). There is also support in decisions of this Court for the proposition that conclusions on mixed questions of law and fact are independently reviewable by an appellate court, *e. g.*, *Bogardus* v. *Comm'r*. 302 U. S. 34, 39 (1937); *Helvering v. Tex-Penn Oil Co.*, 300 U. S. 481, 491 (1937); *Helvering* v. *Rankin*, 295 U. S. 123, 131 (1935). But *cf.*, *Comm'r* v. *Duberstein*, 363 U. S. 278, 289 (1960); *Comm'r* v. *Heininger*, 320 U. S. 467, 475 (1943).

may only reverse a district court's finding on discriminatory intent if it concludes that the finding is clearly erroneous under Rule 52(a). Insofar as the Fifth Circuit assumed otherwise, it erred.

IV

Appellees do not directly defend the Fifth Circuit rule that a trial court's finding on discriminatory intent is not subject to the clearly erroneous standard of Rule 52.[20] Rather, among other things, they submit that the Court of Appeals recognized and, where appropriate, properly applied Rule 52 in setting aside the findings of the District Court. This position has force, but for two reasons it is not persuasive.

First, although the Court of Appeals acknowledged and correctly stated the controlling standard of Rule 52, the acknowledgement came late in the court's opinion. The court had not expressly referred to or applied Rule 52 in the course of disagreeing with the District Court's resolution of the factual issues deemed relevant under *James* v. *Stockman Valves and Fittings, supra.*[21] Furthermore, the paragraph in which the court finally concludes that the USW seniority system is unprotected by § 703(h) strongly suggests that the outcome was the product of the court's independent consideration of the totality of the circumstances it found in the record.

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[20]Neither does the dissent contend that Rule 52(a) is inapplicable to findings of disciminatory intent. Rather, it contends, that the Rule was properly applied by the Court of Appeals.

[21]In particular, in regard to the second *James* factor — whether the departmental structure was rational or in line with industry practice — the Court of Appeals did not focus on the evidentiary basis for any particular finding of the District Court. It appeared to make an independent examination of the record and arrive at its own conclusion contrary to that of the District Court. Likewise, in dealing with the genesis of the seniority system and whether or not the negotiation or maintenance of the system was tainted with racial discrimintion, the Court of Appeals, while identifying what it thought was legal error in failing to consider the racial practices and intentions of IAM, did not otherwise overturn any of the District Court's findings as clearly erroneous.

Second and more fundamentally, when the court stated that it was convinced that a mistake had been made, it then not only identified the mistake but also the source of that mistake. The mistake of the District Court was that on the record there could be no doubt about the existence of a discriminatory purpose. The source of the mistake was the District Court's failure to recognize the relevance of the racial purposes of IAM. Had the District Court "given the IAM's role in the creation and establishment of the seniority system its due consideration," it "might have reached a different conclusion." *Supra*, at 10.

When an appellate court discerns that a district court has failed to make a finding because of an erroneous view of the law, the usual rule is that there should be a remand for further proceedings to permit the trial court to make the missing findings:

> "Fact finding is the basic responsibility of district courts, rather than appellate courts, and . . . the Court of Appeals should not have resolved in the first instance this factual dispute which had not been considered by the District Court." *DeMarco* v. *United States*, 415 U. S. 449, 450n. (1974).[22]

Likewise, where findings are infirm because of an erroneous view of the law, a remand is the proper course unless the record permits only one resolution of the factual issue. *Kelley* v. *Southern Pacific Co.*, 419 U. S. 318, 331-332 (1974). All of this is elementary. Yet the Court of Appeals, after holding that the District Court had failed to consider

[22]See 5A J. Moore, & J. Lucas, Moore's Federal Practice § 52.06[2] (1981) ("Where the trial court fails to make findings, on a material issue, and an appeal is taken, the appellate court will normally vacate the judgment and remand the action for appropriate findings to be made."); *Rule v. International Ass'n of Bridge, etc., Workers*, 568 F. 2d 558, 568 (CA8 1978); *Chicano Police Officer's Ass'n* v. *Stover*, 552 F. 2d 918, 921 (CA10 1977); *O'Neal* v. *Gresham*, 519 F. 2d 803, 805 (CA4 1975); *Burch v. International Ass'n of Machinists & Aerospace Workers, AFL-CIO*, 433 F. 2d 561 (CA5 1970); *General Electric Credit Corp.* v. *Robbins*, 414 F. 2d 208 (CA8 1969).

relevant evidence and indicating that the District Court might have come to a different conclusion had it considered that evidence, failed to remand for further proceedings as to the intent of IAM and the significance, if any, of such a finding with respect to the intent of USW itself. Instead, the Court of Appeals made its own determination as to the motives of IAM, found that USW had acquiesced in the IAM conduct, and apparently concluded that the foregoing was sufficient to remove the system from the protection of § 703(h).[23]

Proceeding in this manner seems to us incredible unless the Court of Appeals construed its own well-established circuit rule with respect to its authority to arrive at independent findings on ultimate facts free of the strictures of Rule 52 also to permit it examine the record and make its own independent findings with respect to those issues on which the district court's findings are set aside for an error of law. As we have previously said, however, the premise for this conclusion is infirm: whether an ultimate fact or not, discriminatiory intent under § 703(h) is a factual matter subject to the clearly erroneous standard of Rule 52. It follows that when a District Court's finding on such an ultimate fact is set aside for an error of law, the Court of Appeals is not relieved of the usual requirement of remanding for further proceedings to the tribunal charged with the task of fact-finding in the first instance.

Accordingly, the judgment of the Court of Appeals is reversed and the case remanded to that court for further proceedings consistent with this opinion.

So ordered.

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[23]IAM's discriminatory motivation, if it existed, cannot be imputed to USW. It is relevant only to the extent that it may shed some light on the purpose of USW or the company in creating and maintaining the separate seniority system at issue in this case. A discriminatory intent on the part of IAM, therefore, does not control the outcome of his case. Neither does the fact, if true, that USW acquiesced in racially discriminatory conduct on the part of IAM. Such acquiescence is not the equivalent of a discriminatory purpose on the part of USW.

Opposition

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No. 81-1791

In the Supreme Court of the United States

OCTOBER TERM, 1981

GROUP LIFE AND HEALTH INSURANCE COMPANY, PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the decision below correctly held that a "disability-disabled lives" reserve established by petitioner equal to 75% of the face amount of insurance in force under its group life insurance policies with respect to those insured individuals whose premiums were waived after they had been disabled for six months or more, was not includable in "life insurance reserves" under Section 801(b) of the Internal Revenue Code.

2. Whether petitioner, who paid a deficiency in income taxes and thereafter filed a claim for refund of that amount, may seek recovery of a greater amount in this refund suit on the ground that it should be deemed to have filed a further "informal" claim for the greater amount based on additional deductions it had sought (and was allowed) on audit as offsets in determining the deficiency proposed by the Commissioner.

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BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINIONS BELOW

The district court's findings of fact and conclusions of law (Pet. App. A1-A18) and its order allowing an additional refund (Pet. App. B1-B3) are not officially reported. The opinion of the court of appeals (Pet. App. C1-C37) is reported at 660 F.2d 1042.

JURISDICTION

The judgment of the court of appeals was entered on November 12, 1981. The order of the court of appeals denying a petition for rehearing and suggestion for rehearing en banc filed on behalf of petitioner (Pet. App. D1-D2) was entered on Janu-

ary 6, 1982. The petition for a writ of certiorari was filed on March 27, 1982. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTES AND REGULATIONS INVOLVED

The relevant portions of Sections 801 and 6511 of the Internal Revenue Code of 1954 (26 U.S.C.) and of Section 301.6402-2(b) of the Treasury Regulations on Procedure and Administration (1954 Code) (26 C.F.R.) are set forth at Pet. 2-4.

STATEMENT

1. Petitioner is a corporation organized under the Texas Insurance Code and is authorized to issue insurance policies covering life, health and accident benefits. Prior to 1967, the year at issue, petitioner issued certain group term life insurance policies providing that premiums for any individual who became disabled for more than six months would be waived for the duration of such disability. As of the end of 1967, there were 23 insured individuals, having total insurance coverage of $112,000, who had been disabled more than six months and whose premiums were therefore being waived under those group policies. At that time, petitioner established a "disability-disabled lives" reserve with respect to those individuals, and made a one-time addition to that reserve of $750 for each $1,000 of insurance coverage.[1] This reserve was in addition to both the regular life insurance reserves maintained by petitioner with respect

[1] Petitioner also established a "disability-disabled lives" reserve, in the amount of $4,958, with respect to disabled insured persons, covered by individual life policies. That amount was apparently computed on the basis of standard mortality tables and is not in issue here.

to the group policies based on the premiums received and an actuarially computed "disability-active lives" reserve that was designed to cover the "extra" policy benefit with respect to the waiver of premiums on disability. The "disability-disabled lives" reserve in question was designed to cover the liabilities resulting from the increased risk of death associated with incurred disabilities (Pet. App. A6, A9-A11, C4-C6).

On its federal income tax return for 1967, petitioner treated the $84,000 added to its "disability-disabled lives" reserve as part of its "life insurance reserves" under Section 801(b) of the Internal Revenue Code of 1954 (26 U.S.C.). As a result of petitioner's inclusion of this and certain other disputed amounts in its "life insurance reserves," petitioner claimed the preferential status of a "life insurance company" for federal income tax purposes under Section 801(a) of the Code.[2] On audit, the Commissioner of Internal Revenue determined that a number of reserves petitioner had treated as "life insurance reserves"—including the $84,000 addition to the "disability-disabled lives" reserve—did not qualify as "life insurance reserves" under Section 801(b), so that petitioner failed to qualify as a life insurance company under Section 801(a). Based on that determination, and taking into account certain other adjustments (including certain additional deductions sought by petitioner during the course of the audit), the Commissioner determined a deficiency in tax for

[2] Under Section 801(a), an insurance company is entitled to the preferential tax treatment accorded "life insurance companies" under Sections 801 through 820 of the Code if its qualifying "life insurance reserves" (plus certain other reserves on non-cancellable life, health or accident policies) comprise more than 50% of its total insurance reserves.

1967 of $446,925.83. Petitioner paid the amount of the asserted deficiency, plus interest, and thereafter filed a claim for refund for that amount, asserting that the amount of taxes owing was the amount shown due on its return (Pet. App. A2-A4, C4, C35).

2. Upon the disallowance of that refund claim, petitioner brought this refund suit in the United States District Court for the Northern District of Texas seeking recovery of the amount it had sought in its claim for refund. Prior to trial, the government conceded that a number of the reserves questioned by the Commissioner's deficiency determination qualified as life insurance reserves. However, there remained in issue the status of the $84,000 "disability-disabled lives" reserve and of certain "unpaid losses". If either of these reserves qualified as "life insurance reserves," petitioner asserted that it would be able to qualify as a life insurance company under Section 801(a) (Pet. App. A4-A5, C7-C8).

The district court agreed with petitioner that the $84,000 addition to the "disability-disabled lives" reserve qualified for inclusion in its "life insurance reserves" under Section 801(b). It therefore found it unnecessary to resolve the status of the disputed "unpaid losses" (Pet. App. A5-A6). In ruling that the "disability-disabled lives" reserve met all of the requirements of Section 801(b), including the requirement that the amounts in question be "computed or estimated on the basis of recognized mortality or morbidity tables and assumed rates of interest" (Section 801(b)(1)(A)), the district court concluded that the use of a reserve factor of $750 to $1,000 of insurance coverage was based on the recommendations of a 1949 Report of the Committee on Mortality and Morbidity of the Society of Actuaries (Pet. App. A10), that the 1949 Report

was itself a recognized mortality and morbidity table and was based on assumed rates of interest (Pet. App. A11), and that the $750 reserve so established "is the average reserve, applying the assumed disability to these reserve tables, and assuming an average time of disability to be four or five years" (Pet. App. A12).

Although petitioner's claim for refund and its original complaint had sought to recover only the amount paid in satisfaction of the deficiency determined by the Commissioner, petitioner thereafter sought the entry of judgment for an additional $147,345.06, based on additional deductions which had not been claimed on its return but which had been sought, and allowed by the Commissioner, in determining the amount of the deficiency. No formal claim for refund was ever filed with respect to that additional amount. The district court nevertheless concluded that petitioner should be treated as having filed an "informal" refund claim based on these adjustments and that the Commissioner had waived the requirement of a formal claim for refund by allowing such deductions in determining the amount of the asserted deficiency. Accordingly, it awarded judgment for both the amount originally claimed and the additional amount sought by petitioner (Pet. App. B1-B3).

3. The court of appeals reversed on both issues. It held that the reserve for "disability-disabled lives" did not satisfy the specific requirements of Section 801(b)(1)(A) that it be estimated or computed on the basis of recognized mortality or morbidity tables and assumed rates of interest.[3] The court noted that

[3] The government argued below that, even apart from the fact that the reserve in question was not computed or esti-

the 1949 Report did contain actuarial data apparently based on mortality rates, assumed rates of interest and the duration of disability, and that, while the data were presented in a more simplistic form than the tabular data used for the calculation of ordinary life insurance reserves, the report "seem[ed] to use the same type of figures, [and] same type of actuarial reasoning" (Pet. App. C15).[4] The court concluded, however, that the record failed to establish (1) that petitioner's actuary had actually based his determination on, or, indeed, that he was even familiar with, the actuarial data provided in the

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mated on the basis of mortality and morbidity tables and assumed rates of interest, it failed to qualify as a life insurance reserve because it was not derived from the payment of net premiums on the policies in question. See pages 12-13, note 10, *infra*.

[4] Contrary to petitioner's assertions (Pet. 9), the court of appeals did not "approve" the use of the tabular data set forth in the 1949 Report. While the court suggested that the tabular data set forth in the 1949 Report might satisfy the requirements of Section 801(b)(1)(A), it expressly declined to resolve that question in light of its conclusion that petitioner's reserve was not "comput[ed] or estimat[ed]" on the basis of those data (Pet. App. C23). The court also noted that, by 1968, more sophisticated actuarial data had become available under a report published in that year which took into account the age of the insured at the time of disability in addition to the factors taken into account by the 1949 Report (Pet. App. C15, C40). The court further noted that petitioner had failed to establish that there were no more appropriate data available in 1967 than were provided by the 1949 Report (Pet. App. C19). But since the court of appeals concluded that petitioner failed to use the 1949 Report correctly, it was unnecessary for it to address petitioner's contention that the 1949 Report was the only authority upon which it could have relied in 1967 (*ibid.*).

1949 Report (Pet. App. C19-C22); (2) that the 1949 Report actually recommended the use of a $750 reserve factor (rather than a figure based on a specific rate of interest and the duration of individual disabilities) (Pet. App. C19, C22-C26)[5]; or (3) that such a $750 reserve factor was derived, in any way, from any mortality or morbidity tables at an assumed rate of interest or that this figure could be computed or estimated from the actuarial data provided by the 1949 Report (Pet. App. C19, C26-C28, C30). It concluded that the district court's contrary findings were unsupported by any credible evidence, and were therefore clearly erroneous (Pet. App. C31-C33). Finally, the court of appeals rejected petitioner's argument, raised for the first time in the court of appeals, that the court could properly compute an appropriately reduced reserve based on the actuarial data set forth in the 1949 Report and permit petitioner to qualify as a life insurance company on that basis[6] (Pet. App. C33). Accordingly, it re-

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[5] We note that there is a printing error at Pet. App. C22, which would change the meaning of this portion of the court of appeals' opinion. In the paragraph beginning at the bottom of that page, one line is repeated, and the following language from the court's opinion (which should appear immediately after the word "report" at the beginning of the third line of that paragraph) was deleted. The deleted line reads as follows: "Group Life further alleges that his recollection of the report * * *" Thus, it is clear that the court was not suggesting that the actuary was "correctly following" the 1949 Report, but that this was petitioner's further allegation. The court's conclusion, of course, was directly to the contrary (Pet. App. C23-C26).

[6] The court had previously noted (Pet. App. C31) that petitioner had failed to show what its reserve would have been if it had been based on the appropriate tables set forth in the 1949 Report.

manded the case for further consideration of petitioner's alternative contentions (*ibid.*).

Although it was not strictly necessary for the court of appeals to resolve the claim for refund issue,[7] it nevertheless reversed the district court on this question as well. The court noted that petitioner had never sought a refund based on the allowance of the additional deductions either formally or informally (Pet. App. C35). It emphasized that petitioner was not merely silent on this matter, but had actually claimed the smaller amount, asserting that the tax liability as originally reported was correct (Pet. App. C36). Finally, the court concluded that the fact that no action taken by the Commissioner administratively could be taken as a formal determination that petitioner had overpaid its taxes for the period in question (Pet. App. C37).

ARGUMENT

1.a. The court of appeals correctly held that petitioner failed to establish that its "disability-disabled lives" reserve, maintained with respect to disabled individuals covered by its group life policies, qualified as a "life insurance reserve" under Section 801(b)(1)(A) of the Code. Under that provision, a qualifying reserve must reflect amounts that are

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[7] To the extent that the Commissioner's determination that petitioner did not qualify, for 1967, as a life insurance company would be sustained on the remand ordered by the court of appeals, petitioner would not be entitled to the refund of any of the amounts sought, even if it were treated as having filed an informal refund claim. As we have noted (*supra*, page 3), petitioner was given the benefit of the additional deductions in the computation of the deficiency resulting from that determination.

"computed or estimated on the basis of recognized mortality or morbidity tables and assumed rates of interest." As the court of appeals concluded, petitioner's addition to the reserve of the flat sum of $750 for each $1,000 of insurance coverage for disabled individuals was not shown to have been estimated or computed on the basis of either recognized mortality tables or assumed rates of interest. Thus, even assuming such an additional reserve for disabled individuals would qualify for inclusion in "life insurance reserves" if it had been actuarially determined (see pages 12-13, note 10, *infra*), petitioner's reserve failed to qualify for inclusion in its "life insurance reserves." Accordingly, the court of appeals properly remanded the case for consideration of petitioner's alternative arguments in support of its claim for qualification as a "life insurance company" for tax purposes.

Petitioner's contention that its "disability-disabled lives" reserve satisfied the requirements of Section 801(b)(1)(A) is based on the premises (1) that it was established on the basis of a recommendation set forth in the 1949 Report of the Committee on Group Mortality and Morbidity of the Society of Actuaries; and (2) that that recommendation could itself be taken as reflecting an estimate based on mortality tables and an assumed rate of interest. As the court of appeals noted, however, that contention is erroneous in at least three material respects. First, the actuary who actually established this reserve testified that he did not, in fact, refer to the 1949 Report (or to any other actuarial data) in determining the amount of the reserve in question (Pet. App. C20). Indeed, as the court below pointed out (Pet. App. C22), his testimony indicates that he was, at best, only vaguely familiar with the contents of

that Report. To the contrary, his recommendation was based upon his recollection that the use of a 75% reserve factor was in accordance with an industry "rule of thumb"—not that this "rule of thumb" was itself based either on any particular assumed rate of interest or on any compilation of actuarial data of the sort that underlies generally recognized mortality and morbidity tables.

Nor can the reserve be deemed to satisfy Section 801(b)(1)(A) on the theory that the recommendation of petitioner's actuary was nevertheless unwittingly in accord with the recommendations of the 1949 Report. As the court concluded, the record falls far short of establishing that the 1949 Report could even be read as making such a recommendation for the use of a 75% reserve factor for disabled insureds. The Report does contain a statement with regard to "adding to the death claims 75% of the number of approved disability claims" (Pet. App. C23). But the precise significance of that statement is left totally obscure, by both the Report itself and the testimony presented below.

Moreover, it is significant that the Report sets forth a table of "disability claim reserves" (Pet. App. C39) based on duration of disability and assumed rates of interest (showing generally much smaller reserves than that in question here, except in the ninth and tenth years of disability).[8] But petitioner demonstrated no correlation between the asserted 75% factor and these tabular reserves. Further, petitioner's contention below (Pet. App. C26) that the 75% factor represents an estimate of the single net premium required to fund such policies is belied by the fact that the Report set forth a table showing

[8] It does not appear that any of the insured individuals in question had been disabled for such a period.

such net premiums of amounts ranging from $400.81 to $557.45 per $1,000 of coverage (Pet. App. C39).

At all events, even on the assumption that the reference in the 1949 Report to a 75% factor could be taken as a specific recommendation for establishing reserves in the flat sum of $750 for each $1,000 of insurance coverage (regardless of the age of the insured or the duration of his disability), the record fails to support the contention that that figure could itself be considered to be an estimate based on mortality tables and an assumed rate of interest. Assuming, arguendo, that the tabular data set forth in Tables IV and V of the Report could be considered to meet the requirements of Section 801(b)(1)(A),[9] there is no indication on the face of the Report—and no showing by credible evidence—that the 75% reserve factor used by petitioner and assertedly recommended by the Report was itself based on that actuarial data. Not until after nine or ten years of disability would a reserve for any individual insured approaching $750 per $1,000 of coverage be justified by the actuarial data set forth in the Report (Pet. App. C28, C39). Accordingly, such a factor could not be said to represent an "average" reserve based on such data.

Moreover, while the tabular data of the 1949 Report were presented in separate formats using specific assumed interest rates of 2½ and 3%,

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[9] As the court of appeals noted (Pet. App. C15), the data in the 1949 Report are relatively unsophisticated, as compared with the actuarial tables set forth in the 1968 Report of the Committee on Group Life and Health Insurance. The latter report generally provides for far lower reserves for nearly all age groups, but was of course not available to petitioner during the year in question (1967). As the court further noted (Pet. App. C19), however, there was no showing that comparable data were not available in other forms by that time.

there is no indication that the so-called industry "rule of thumb" followed here was based on any particular assumed rate of interest. As the court of appeals concluded, the contrary findings of the district court have no credible support in the record. Thus, even if petitioner were correct in both its contention that the reserve in question was based on the 1949 Report and its further contention that the 1949 Report recommended the use of such a flat sum reserve of $750 per $1,000 of coverage, the reserve established would nevertheless fail to meet the requirements of Section 801(b)(1)(A).[10]

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[10] It was therefore unnecessary for the court of appeals to reach the government's further contention that this reserve would not qualify, in any event, for inclusion in "life insurance reserves" because it was not built up, as ordinary life insurance reserves are, out of the net premiums received on the policies in question. By the time the statutory definition of the term "life insurance reserves" began to take its current form under Section 163 of the Revenue Act of 1942, ch. 619, 56 Stat. 798, it had long been established that the term "reserve funds" employed in the predecessors to that statute comprehended only those "technical" reserves that were, in fact, derived from the receipt of premiums and not other types of reserves designed to cover other risks and liabilities. *McCoach* v. *Insurance Co. of North America*, 244 U.S. 585 (1917); *Maryland Casualty Co.* v. *United States*, 251 U.S. 342, 350-351 (1920); *United States* v. *Boston Insurance Co.*, 269 U.S. 197 (1925); *New York Insurance Co.* v. *Edwards*, 271 U.S. 109, 119-120 (1926). While such a requirement was not expressly set forth in the definition adopted by Section 163 of the 1942 Act, there is nothing in the legislative history of that Act that would indicate that Congress intended to abrogate this long established distinction.

Petitioner's reliance (Pet. 14, 21) upon *Mutual Benefit Life Insurance Co.* v. *Commissioner*, 488 F.2d 1101 (3d Cir. 1973), cert. denied, 419 U.S. 882 (1974), is misplaced. There, the court held that an additional reserve set up for settlement options on life insurance policies was a "life

b. Petitioner further argues (Pet. 10, 12, 15-19, 22-23) that the court of appeals' refusal to accord its "disability-disabled lives" reserve the status of

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insurance reserve" even though it was not computed solely from accepted mortality tables and assumed rates of interest. In so holding, the court observed that "[t]here is nothing in the statute which states that [mortality tables and assumed rates of interest] are the only factors which are permissible and all others must be excluded" (488 F.2d at 1107). Although we believe that *Mutual Benefit* was wrongly decided, the settlement option reserve in that case is not comparable to the disability-disabled lives reserve at issue in this case. Here, in contrast, the court below concluded there was no evidence that it was computed on any mortality or morbidity tables at an assumed rate of interest (Pet. App. C19). *Mutual Benefit* is therefore distinguishable.

Presumably, the premium structure for the group policies here in question was designed to provide sufficient net premiums to cover all of the liabilities that were actuarially projected under these policies. Thus, the ordinary reserves on these policies (coupled with the actuarially computed "disability-active lives" reserve providing for the waiver of premium benefit under these policies) was presumably sufficient, in total amount, to cover all risks under the policies. While the establishment of yet another reserve, as individual insureds become disabled, might be prudent, such a reserve does not fit within the concept of qualifying reserves established by the early cases, and bears no relationship to the original and underlying function of that concept in providing a basis for determining what portion of current receipts belongs, in effect, to the policyholders and what portion of those premiums should be taxed to the company. See *McCoach* v. *Insurance Co. of North America, supra*, 244 U.S. at 589.

To be sure, the court below did note (Pet. App. C30) that a "disability-disabled lives" reserve might, in some circumstances, qualify as a "life insurance reserve." But the reserves described in the two authorities cited by the court as examples of such "life insurance reserves" were quite different in nature from the reserve involved here. In Rev. Rul. 70-190, 1970-1 Cum. Bull. 150, the "disability-disabled lives"

qualifying life insurance reserves is in conflict with this Court's decision in *United States* v. *Consumer Life Insurance Co.*, 430 U.S. 725 (1977), or with *Central National Life Insurance Co.* v. *United States*, 574 F.2d 1067 (Ct. Cl. 1978) (Pet. 10, 12, 15-19). The issue in *Consumer Life*—whether "unearned premiums" should be attributed, for tax purposes, to the company that held the funds or to a different company that bore the insurance risk—is wholly unrelated to the issue presented here. In ruling for the companies in that case, this Court emphasized that their treatment of the reserves in question had been approved by the state insurance authorities (425 U.S. at 751). But the State's acceptance of the reserve in question here has no bearing whatsoever on whether that reserve satisfied the specific statutory requirement set out by Section 801(b)(1)(A) of the Code. There is no question here that this reserve is attributable to petitioner and that it is therefore includable in its "total reserves" for federal tax purposes. All that is at issue is whether it is includable in the numerator ("life insurance reserves") of the qualification ratio provided for by Section 801(a) as well as in the denominator ("total reserves") of that ratio. Since there is no indication that acceptance of the reserve by the state insurance department was premised, in any way, on

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reserve was not designed to cover increased risks regarding the liability covered by the ordinary life reserves, but to cover payment of disability benefits that were due to the disabled individuals. Moreover, in *Commissioner* v. *Monarch Life Insurance Co.*, 114 F.2d 314, 320-321 (1st Cir. 1940), the reserve was designed (like the "disability-active lives" reserve maintained by petitioner here)—to provide a fund that would cover the usual net premiums that would be waived during periods of disability.

whether it was actuarially computed or estimated on the basis of mortality tables and an assumed rate of interest, as Section 801(b)(1)(A) specifically requires, the state's acceptance has no bearing upon the question presented.

Central National Life Insurance Co. is likewise distinguishable. In that case, the court sustained the inclusion in "life insurance reserves" of an ordinary reserve maintained on the basis of gross premiums (rather than the net premiums) received under the policies in question. But, as the court below correctly observed (Pet. App. C31), the issue in that case was materially different. There, the premiums on which the reserve in question was based were themselves necessarily based, at least indirectly, on mortality tables, even though gross premiums are themselves incrementally larger, in ordinary circumstances, than the net premiums required to cover the insurance benefits provided by the policy. Here, in contrast, petitioner's reserve was not shown to be geared, in any way, either to premiums or to assumed interest rates and mortality tables with respect to the risks in question. Moreover, unlike the taxpayer in *Central Life Insurance Co.*, the taxpayer here failed to establish precisely what amount would have been added to the reserve in question if it had been established and maintained on the basis of available mortality tables and an assumed interest rate. Thus, the finding that the reserve in question in *Central National Life Insurance Co.* qualified as an estimate based on mortality tables and an assumed rate of interest is not inconsistent with the contrary determination that the reserve here was not shown to be such a qualifying estimate.

c. Finally, the court below was amply justified in rejecting petitioner's further argument (Pet. 17-19)—never fully developed in either the district

court or the court of appeals—that it should approve the inclusion in "life insurance reserves" of at least that part of the flat-sum addition to the reserve in question that would be equal to the reserve that would have been established had petitioner calculated the reserve, in the first instance, on the basis of available mortality tables and an assumed rate of interest. Assuming, arguendo, that such a recalculation would be permissible in order to credit petitioner with a qualifying reserve, even though the reserve it had actually established failed to meet the statutory requirements, the critical distinction between this case and *Central National Life Insurance Co.* (in which the court referred to the inclusion of such a lesser amount in qualifying "life insurance reserves" as an alternative basis for its decision (574 F.2d at 1082)) is that, there, the taxpayer had proved precisely what such a reserve would have been. Here, on the other hand, petitioner seems to have relied, in the district court, on an "all or nothing" approach and did not attempt to establish the appropriate reserve that would be actuarily based on available mortality tables and an assumed interest rate. It now contends (Pet. 18-19) that the underlying actuarial data were available so that the court of appeals, in effect, might have performed the role of an actuary and calculated the amount of a qualifying reserve based on the 1949 Report. The court, however, was not required to assume that role in the absence of any expert testimony as to the precise amount of the reserve or any proof establishing that the data provided by the 1949 Report were, in fact, the only actuarial data available in 1967 for determining the appropriate amount of such a reserve.[11]

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[11] Petitioner asserts (Pet. i n.1) that the same issue is pending administratively in a number of other cases awaiting

2. The court of appeals further correctly held that even assuming petitioner were able to establish, on remand, that it qualifies under Section 801(a) as a "life insurance company" on the basis of its alternative arguments, its recovery should be limited to the amount sought in its only formal claim for refund. Section 7422(a) of the Code specifically provides that no suit may be maintained for the recovery of any internal revenue tax "until a claim for refund or credit has been duly filed with the Secretary, according to the provisions of law in that regard, and the regulations of the Secretary established in pursuance thereof." Under Treasury Regulation, Section 301.6402-2(b) (26 C.F.R.), such an administrative claim for refund must be timely filed[12] and must "set forth in detail each ground upon which a credit or refund is claimed and facts sufficient to apprise the Commissioner of the exact basis thereof."

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the outcome of this case. We have been advised by the Chief Counsel, Internal Revenue Service, that there are a number of pending cases, involving about $14.8 million in tax, which present similar questions under Section 802(b)(1)(A). Nevertheless, this particular decision is not appropriate for review on grounds of administrative importance. First, although a number of insurance companies apparently followed a similar "rule of thumb," at least for years before the 1968 Report became available, it appears that many, if not most, insurance companies now compute their "disability-disabled lives" reserves on an actuarial basis. Second, there are alternative contentions, not developed here, in many of the pending cases concerning the qualification of the reserves in question under Section 802(b). Finally, to the extent the decision here turns on a failure of proof on the part of petitioner, it would not necessarily be dispositive even as to the Section 802(b)(1)(A) question in those cases.

[12] Under Section 6511(a) of the Code, a claim for credit or refund of an asserted overpayment of tax must be filed within three years after the return was filed or two years after the time the tax was paid, whichever period expires later.

Here, the only formal claim for refund filed by petitioner in compliance with these provisions was its claim seeking the recovery of the amount paid pursuant to the Commissioner's deficiency determination. That claim not only failed to seek the recovery of any additional amount, but specifically asserted that the amount paid with the return was the amount of taxes owed (Pet. App. C36).[13] It has, of course, long been established that, while the Commissioner may insist on full compliance with the formal requirements set forth in the Treasury Regulations, he may also waive those formal requirements so as to permit consideration of grounds for a refund other than those specifically set forth in the refund claim. See, *e.g.*, *Tucker* v. *Alexander*, 275 U.S. 228 (1927); *Angelus Milling Co.* v. *Commissioner*, 325 U.S. 293, 296 (1945). The statutory requirement that a refund claim be timely filed, however, is mandatory, and, unlike the formal requirements set forth in the Treasury Regulations, cannot be waived. See *United States* v. *Garbutt Oil Co.*, 302 U.S. 528, 533-535 (1938); *United States* v. *Memphis Cotton Oil Co.*, 288 U.S. 62, 71 (1933).

Petitioner, however, asserts that it can be deemed to have filed an "informal" claim for refund in light of its assertions, advanced during the course of the audit, that it was entitled to additional deductions not claimed on its return. If that were true, virtually any claims that are asserted and considered on audit could be pursued in a refund suit without the necessity of following the ordinary refund claim requirements. Indeed, under that theory, since peti-

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[13] Indeed, by the time that refund claim was filed (on Nov. 12, 1973), the time for filing a claim for the refund with respect to the taxes paid with the return (which was filed on Sept. 16, 1968 (Pet. App. B1)) had long since expired.

tioner had vigorously asserted that it qualified for taxation as a life insurance company, it could have immediately filed suit, once the deficiency was satisfied, without having filed the formal refund claim that it did file.

The authorities cited by the petitioner do not support its contentions that such informal assertions during the course of an audit can be considered as a claim for refund sufficient to satisfy the requirement set forth in Section 7422(a) of the Code. In *United States* v. *Kales*, 314 U.S. 186 (1941), for example, the letter that was treated as such a claim expressly sought a refund of the amount in question. Moreover, in *Bonwit Teller & Co.* v. *United States*, 283 U.S. 258 (1931), the Commissioner had determined that there was, in fact, an overpayment of taxes for the year in question and there was a course of correspondence concerning the taxpayer's entitlement to recover that overpayment. Indeed, the suit was characterized by the Court not as a suit for the refund of an overpayment of tax, per se, but as a suit for an "account stated" based on the Commissioner's certificate of overassessment. 283 U.S. at 265.

Here, by contrast, there was no evidence of any written claim by petitioner, either formal or informal, for a refund of taxes paid with the return. Cf. *John S. Furst* v. *United States*, No. 415-80T (Ct. Cl. Apr. 21, 1982).[14] Moreover, the orally

[14] In *John S. Furst*, the Court of Claims allowed a taxpayer to be treated as having filed an "informal" refund claim for years not covered by the formal refund claim where, *inter alia*, the taxpayer had filed a written protest with respect to all of the years, and the formal refund claim referred to the determinations for the other years. In so holding, the court reaffirmed (slip op. 6) its earlier decision in *Disabled American Veterans* v. *United States*, 650 F.2d 1178, 1179-1180

communicated assertions that were made concerned the allowance of additional deductions as offsets in determining the amount of the deficiency proposed by the Commissioner, and did not seek the refund of any portion of the taxes that had been paid. Nor does the allowance of such additional deductions for that purpose stand on the same footing as the certificate of overassessment issued in *Bonwit Teller*, since there was plainly no determination by the Commissioner that petitioner had overpaid its taxes for the year in question. The court of appeals therefore correctly concluded that petitioner's actions in seeking these additional deductions during the audit of its return did not constitute an informal claim for a refund of any portion of the taxes it paid with its return. See, *e.g.*, *Tobin* v. *Tomlinson*, 310 F.2d 648 (5th Cir. 1962); *Philipsborn* v. *United States*, 53 F.2d 133, 138 (Ct. Cl. 1931), cert. denied, 285 U.S. 548 (1932); *Hollie* v. *Commissioner*, 73 T.C. 1198, 1212-1214 (1980).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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(1980), that even an informal claim must be presented in written form and that oral representations made during the course of an audit would not meet the requirements of Section 7422(a).

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